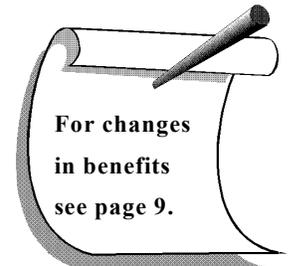




A Prepaid Comprehensive Medical Plan with a Point-of-Service product



Serving: All of Western Washington

Enrollment in this Plan is limited. You must live or work in our Geographic Service area to enroll. See page 7 for requirements.

Enrollment codes for this Plan:

High Option

VT1 Self Only

VT2 Self and Family

Standard Option

L11 Self Only

L12 Self and Family

Special Notice:

We are eliminating Standard Option enrollment codes VT4 and VT5. If you were a Standard Option enrollee, you will be automatically transferred to High Option, unless you make an Open Season change. Please review the High Option benefits described in this brochure carefully.

Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>



**Federal Employees
Health Benefits Program**

RI 73-051



OFFICE OF THE DIRECTOR

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season – especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this brochure, our FEHB Guide, and our web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on www.opm.gov/insure!

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your healthcare needs. Use this brochure, the FEHB Guide, and the web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

Kay Coles James
Director



Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

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Introduction

This brochure describes the benefits of KPS Health Plans under our contract (CS 1767) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for KPS Health Plans administrative offices is:

KPS Health Plans
400 Warren Avenue, P.O. Box 339
Bremerton, Washington 98337

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, 2004, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2004 and changes are summarized on page 9. Rates are shown at the end 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 example, “you” means the enrollee or family member; “we” means KPS Health Plans.
- 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 OPM 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 United States 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:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) 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 360-478-6796 or toll free at 800-552-7114 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 DC 20415-1100**

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child age 22 or older (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.**
 - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
 - Tell them about any drug allergies you have.
 - Ask about side effects and what to avoid while taking the medicine.
 - Read the label when you get your medicine, including all warnings.
 - Make sure your medicine is what the doctor ordered and know how to use it.
 - Ask the pharmacist about your medicine if it looks different than you expected.
3. **Get the results of any test or procedure.**
 - Ask when and how you will get the results of test 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 reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.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 healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.talkaboutrx.org/consumer.html. 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 healthcare 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 healthcare delivery system.

Section 1. Facts about this plan

We are a Prepaid Comprehensive Medical Plan with a Point-of-Service product. This means that we offer health services in whole or substantial part on a prepaid basis, with professional services provided by individual physicians who agree to accept the payments provided by the Plan and the members' cost-sharing amounts as full payment for covered services.

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

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

We also have Point-of-Service (POS) benefits:

Our Plan offers Point-of-Service (POS) benefits. This means you can receive covered services from a non-Plan provider without a referral. Services received from non-Plan providers or at non-Plan facilities have higher out-of-pocket costs than services received from Plan providers and facilities. Please see Section 5(i) for POS benefit details.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your deductible (if applicable), copayments or coinsurance. We pay dental providers based on a scheduled allowance amount, and you will only be responsible for the deductible (basic dental care only) and charges ***over and above*** the scheduled allowance amount.

We emphasize comprehensive medical and surgical care in Plan doctors' offices and hospitals. A Plan doctor is a Medical Doctor (MD), Doctor of Osteopathy (DO), or Doctor of Naturopathy (ND) participating with KPS, and includes doctors participating in the First Choice Health Network (FCHN), MultiPlan National Provider Network and Providence Health System PPO. A Plan dentist is any licensed dentist within the United States. Our Plan pharmacy benefit management company is MedImpact.

For the purposes of a dependent child or when you are on temporary duty assignment residing outside the state of Washington, a Plan provider is a MultiPlan provider; or in Alaska, Montana and Idaho, a Plan provider is a First Choice Health Network provider; and in Oregon, a Plan provider is with the Providence Preferred Provider Organization. If a Plan provider is not available in your or your dependent's temporary county of residence, then you or your dependent may see any licensed doctor practicing within the temporary county of residence and we will pay those claims based on the billed amount at the appropriate benefit level for the services provided.

We arrange with doctors (2,255 primary care physicians; 9,103 specialists; 2,395 behavioral health providers; 2,299 alternative care providers) and hospitals (82) to provide medical care for both the prevention of disease and the treatment of serious illness.

Your rights

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

If you want more information about us, call 360-478-6796 or toll free 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699; or write to P.O. Box 339, Bremerton, Washington 98337. You may also contact us by fax at 360-415-6514 or visit our Web site at www.kpshealthplans.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area covers the following western Washington counties: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum and Whatcom.

As described above in "How we pay providers", if you receive care from non-Plan providers, we will pay benefits based on our fee schedule/negotiated rates. You will be responsible for any copayments, coinsurance, deductible and any *additional* balance billed by a non-Plan provider. Please see Section 5(i) for POS benefit details.

If you or a covered family member move outside of our service area, you may enroll in another plan. Please contact us first, however, at 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699 to confirm there are no Plan providers available where you or a covered family member may be moving. If you and/or your family 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 2004

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

Program-wide changes

- We added information regarding two new Federal Programs that complement FEHB benefits, the Federal Flexible Spending Account Programs - *FSAFEDS* and the Federal Long Term Care Insurance Program. See page 70.
- We added information regarding Preventing medical mistakes. See page 5.
- We added information regarding enrolling in Medicare. See page 59.
- We revised the Medicare Primary Payer Chart. See page 61.

Changes to this Plan

- **For High Option Enrollees, codes VT1 and VT2**, your share of the non-Postal premium will **decrease** by 49.3% for Self Only and by 49.8% for Self and Family.
- **For Standard Option enrollees who are being moved from codes VT4 and VT5 to VT1 and VT2**, your share of the non-Postal premium will increase by 21.8% for Self Only or 23.2% for Self and Family.
- **For both High Option and Standard Option the following apply:**
 - We have added Clark, Cowlitz, Island, Lewis, Pacific, San Juan, Skagit, Skamania, Snohomish, Wahkiakum and Whatcom counties to our service area — see Section 1
 - We have added Neurodevelopmental Therapies benefit information — see Section 5(a)
 - We have added a Special Features section — see Section 5(g)
 - We have added Section 5(i), Point-of-Service (POS) benefits
 - We have added the Providence Preferred Provider Organization to our provider network — see Section 1
 - We have added the Walgreens Pharmacy mail order program for prescription drugs — see Section 5(f)
 - We have added five days of inpatient hospice care — see Section 5(c)
 - We have increased chiropractic and acupuncture treatments from 12 to 18 per calendar year — see Section 5(a)
 - We have added “master of social work” (M.S.W.), licensed massage therapists, occupational therapist and naturopaths to our list of Plan providers to comply with the Washington State “Every Category of Provider” law — see Sections 3 and 5(a)
 - We have increased full mouth or panorex X-rays coverage from once every five years to once every three years — see Section 5(h)
 - We have increased bitewing X-rays coverage from once a year to twice per calendar year — see Section 5(h)
 - We have decreased the combined lifetime maximum for orthopedic and prosthetic devices and durable medical equipment from \$50,000 to \$10,000 — see Section 5(a)
 - We have added osteoporosis screening for women 65 and older — see Section 5(a)
 - We have added surgical treatment for Temporomandibular Joint Disorders (TMJ) and removed the \$1,000 limit — see Section 5(a)
- **For High Option the following apply:**
 - We have changed the High Option out-of-pocket maximum from \$1,000 per family member to \$5,000 per person or per family — see Section 4
 - We have increased office visit copayments from \$10 to \$15 — see Sections 5(a), 5(d) and 5(e)
 - We have added a \$25 office visit copayment for specialty care — see Section 5(a)
 - We have changed the at home physician care benefit from a \$15 copayment to 20% coinsurance — see Section 5(a)
 - We have changed the maternity care benefit from a \$100 per day copayment with a \$1,000 maximum per calendar year to 20% coinsurance — see Section 5(a)

- We have changed most benefits that had 100% coverage to 20% coinsurance — see Sections 5(a), 5(b), 5(c) and 5(d)
- We have changed the home health services benefit from 100% coverage to a \$15 copayment per visit — see Section 5(a)
- We have changed benefits with a \$10 copayment to 20% coinsurance — see Sections 5(a) and 5(e)
- We have changed the inpatient hospital room and board benefit from a \$100 per day copayment with a \$1,000 maximum per calendar year to 20% coinsurance — see Section 5(c)
- We have increased the Emergency Room copayment from \$25 to \$75 — see Section 5(d)
- We have decreased the temporomandibular joint disorders (TMJ) benefit from 100% coverage to 20% coinsurance
- We have removed the deductible for Tier 2 and Tier 3 prescription drugs — see Section 5(f)
- We have added a \$20 copayment for Tier 2 prescription drugs and a \$100 copayment or 50% coinsurance (whichever is less) for Tier 3 prescription drugs — see Section 5(f)
- We have added separate prescription drug copayments on Tier 1 and Tier 2 prescription drugs for those with Medicare Parts A & B — see Section 5(f)
- We have added Preventive and Basic dental care — see Section 5(h)
- **For Standard Option the following apply:**
 - We have changed the Standard Option out-of-pocket maximum from \$3,000 per person or \$6,000 per family to \$5,000 per person or per family — see Section 4
 - We have increased the annual deductible from \$200 to \$350 per person and from \$400 to \$700 per family — see Section 4
 - We have changed the Preventive care, adult benefit from 20% coinsurance to 100% up to \$500 — see Section 5(a)
 - We have changed the Preventive care, children benefit from 100% unlimited to 100% up to \$500 — see Section 5(a)
 - We have changed the primary care office visit benefit from a flat \$20 copayment to a \$15 copayment for the first three visits then deductible and 20% coinsurance apply to all subsequent visits — see Section 5(a)
 - We have changed some benefits from 20% coinsurance to a \$15 copayment for the first three visits — see Section 5(a)
 - We have added a \$100 per day copayment up to a \$500 maximum per admission to the inpatient hospital room and board benefit — see Section 5(c)
 - We have changed emergency care in a doctor's office or urgent care center (in or out of our service area) from a \$20 copayment to 20% coinsurance — see Section 5(d)
 - We have increased the Tier 1 prescription drug copayment from \$5 to \$10 and Tier 2 from \$20 to \$30 — see Section 5(f)
 - We have changed Tier 3 prescription drug coverage from \$100 or 50% whichever is less to 50% with a \$40 minimum prescription price — see Section 5(f)
 - Basic dental care is no longer a benefit; preventive care *only* is covered — see Section 5(g)

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 (for annuitants); or your 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 us at 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699; or write us at:

KPS Health Plans
P.O. Box 339
Bremerton, Washington 98337.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, or coinsurance, and your deductible (if applicable), and you will not have to file claims.

You get dental care from any licensed dentist within the United States.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

Our provider directory lists primary care providers with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Services department at 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699. You can also find out if your doctor participates with us by calling these numbers. If you are interested in receiving care from a **specific** provider who is listed in the directory, call the provider to verify that he or she still participates with us and is accepting new patients.

- **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 the provider directory, which we update periodically. This information is also on our Web site at www.kpshealthplans.com.

What you must do to get covered care

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

- **Primary care**

Primary care providers are family practitioners, general practitioners, pediatricians, obstetricians/gynecologists, naturopaths, physician assistants (under the supervision of a physician), or advanced registered nurse practitioners (ARNPs).

- **Specialty care**

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

- If you have a chronic or disabling condition and lose access to your specialist because we:

- 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.

- **Complementary care**

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

- Acupuncturist
- Chiropractor
- Massage therapist

When receiving services from these providers, you are subject to the same benefit conditions and limitations that exist for other Plan providers. In addition, spinal manipulations and acupuncture needle treatments are each limited to 18 treatments per calendar year, and massage therapy is part of the physical, rehabilitation and speech therapy benefit (see Section 5(a)). The non-Plan provider reduction in benefits applies (see Section 5(i), Point-of-service benefits).

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699. If you are new to the FEHB Program, we will arrange for you to receive care.

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 case, 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

For certain services you or your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process pre-authorization or pre-certification.

You or your physician must obtain pre-authorization for the following:

- | | | |
|--|--|--|
| • Blepharoplasty | • Inpatient services | • Respiratory syncytial virus agent |
| • Bone growth stimulators | • Insulin pump | • RSV immunization |
| • Breast surgeries | • LAUP | • Sclerotherapy |
| • CPM machines | • Mental health & substance abuse treatments | • Skilled nursing facility care |
| • Electric scooters | • Neuromuscular stimulators | • Sleep disorders |
| • Enteral therapy | • Organ transplants | • SPECT scans |
| • Genetic testing | • Penile prosthesis | • Synchromed pump |
| • Growth hormone treatment (pre-authorized by MedImpact) | • PET scans | • UPPP |
| • Home health & hospice | • Pneumatic compression device | • Urinary incontinence treatment w/biofeedback |
| • Home IV infusion | • Pulse dye laser | • Ventilators |
| • Hospitalization | • Removal of scars | |
| • Hyperbaric oxygen pressurization | | |

Review Section 5, Benefits for additional information regarding pre-authorization.

Help us control costs

• **Outpatient Surgery**

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

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

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

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

The following procedures must be performed on an outpatient basis:

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

• **Pre-Admission Testing**

Pre-admission testing requires that necessary routine diagnostic tests be performed on an outpatient basis before you are hospitalized for elective non-emergency care. These must be performed within three (3) days of the scheduled admission. Failure to obtain testing prior to admission will result in a 20% reduction of benefits for the testing charges. Pre-admission testing is less expensive when done on an outpatient basis and is usually more convenient.

When inpatient hospitalization is recommended for you, ask your Plan doctor to schedule diagnostic tests on an outpatient basis within three (3) days of admission. Pre-admission certification provides advanced confirmation for benefits from us before you are admitted to a hospital or skilled nursing facility.

• **Pre-Admission Certification**

Pre-admission certification authorizes inpatient hospital benefits and is valid for six (6) months. Approval for each admission or re-admission is required. We will provide coverage only for the number of hospital days that are medically necessary and appropriate for your condition. If your hospital stay is extended due to complications, your Plan doctor must obtain benefit authorization for the extension.

After your Plan doctor notifies you that hospitalization or skilled nursing care is necessary, ask your Plan doctor to obtain pre-admission certification. You and your Plan doctor must request pre-admission certification before hospitalization. This is a feature that allows you to know, prior to hospitalization, which services are considered medically necessary and eligible for payment under this Plan. If the hospitalization and treatment is not pre-certified, our allowance for the admitting physician's fees will be reduced by 20% and benefits for the hospital stay will be reduced by \$500.

We will send you written confirmation of the approved admission, once certification is obtained. If an emergency admission occurs, have your attending physician and the hospital contact us within 48 hours of admission, or as soon as reasonably possible, to complete the certification process.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

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

Under High Option you pay a copayment of \$15 per primary care provider* office visit and \$25 per specialist office visit.

*Primary care providers are family practitioners, general practitioners, pediatricians, obstetricians/gynecologists, naturopaths, physician assistants (under the supervision of a physician), or advanced registered nurse practitioners (ARNPs).

Under Standard Option you pay a copayment of \$15 (no deductible) per visit for the first three (3) professional office visits (first three visits may be any combination of primary care, alternative care, rehabilitation, mental health/substance abuse visits) then applicable deductible and 20% coinsurance.

Example:

 - Your first visit of the year is with a primary care doctor; you pay \$15.
 - Your second visit of the year is with a chiropractor; you pay \$15.
 - Your third visit of the year is with a physical therapist; you pay \$15.
 - Starting with your fourth professional office visit, and for all additional office visits, you will pay the applicable deductible and 20% coinsurance.
- **Deductible**

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

 - **There is no annual deductible for High Option medical benefits.** You will, however, pay an annual deductible of \$25 per member (\$50 maximum per family) for Basic dental care and all charges in excess of the scheduled fee allowance.
 - **The Standard Option** calendar year deductible is \$350 per person.
 - **Under Standard Option Family Enrollment**, the calendar year deductible is considered satisfied for all family members when their combined covered expenses applied to the calendar year deductible reach \$700.
 - The deductible is waived for the first three (3) professional office visits (see **Copayments** above), preventive care and accidental injuries.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

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

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance doesn't begin until you meet your deductible. You pay 20% coinsurance for most services.

Example: In our Plan, you pay 50% of our allowance for infertility services; sleep disorders and treatment of morbid obesity.
- **Difference between our allowance and the billed amount**

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

When you choose a Plan provider, your out-of-pocket costs are the least. Plan providers agree to limit what they will bill you. Because of that, when you use a Plan provider, your share of covered charges consists only of your deductible (if applicable), coinsurance or copayment.

If you choose a non-Plan provider, your out-of-pocket costs are significantly higher because they have no agreement to limit what they will bill you. When you use a non-Plan provider the KPS allowed amount for covered services is reduced by twenty-five percent (25%). In addition, it is your responsibility to pay the difference between any amounts billed by the non-Plan provider or facility and the amount paid by KPS.

The following table illustrates how much you have to pay out-of-pocket for services from a Plan provider versus a non-Plan provider. The table uses the example of a service for which the provider charges \$150 and our allowance is \$100. The example applies to both High Option and Standard Option assuming the Standard Option annual deductible has been met.

Example	Plan Provider	Non-Plan Provider
Provider's charge	\$150	\$150
Our allowance	We set it at: 100	We set it at: 100
Our allowance reduced by 25%?	No: 100	Yes: 75
We pay	80% of our allowance: 80	80% of our reduced allowance: 60
You owe coinsurance	20% of our allowance: 20	20% of our reduced allowance: 15
+ Difference up to charge?	No: 0	Yes: 75
Total You Pay	\$20	\$90

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

- **Medical Emergency.** Emergency care is covered in full after you have met any applicable copayment, coinsurance or other cost-sharing obligations. If you are admitted to a non-Plan hospital as a result of your emergency, KPS reserves the right to arrange for your transportation to a Plan hospital (see Section 5(d), Emergency services/accidents).
- **Services Not Available from Plan Providers/Facilities.** KPS has the right to determine whether care and services are or are not available from a Plan provider or facility. If you believe the care or service you require is not available from a Plan provider or facility, please contact KPS Member Services at 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699 *before* obtaining the care or service and ask for a review to determine if it is appropriate for you to see a non-Plan provider. If KPS determines that the care or service you require can only be obtained from a non-Plan provider, your care will be covered in full after you have met any applicable copayment, coinsurance or other cost-sharing obligations.

If you could have received your care from a Plan provider or facility, but **chose** to receive care from a non-Plan provider or facility, you are financially responsible for paying the difference between the amount paid by KPS and the amount billed by the non-Plan provider or facility. This is called 'balance billing'.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

For both High Option and Standard Option, after your copayments, coinsurance and deductible (Standard Option only) total \$5,000 per person or \$5,000 per family enrollment in any calendar year, you do not have to pay any more for covered services.

However, the copayments, coinsurance or deductible for the services listed below do not count toward your out-of-pocket maximum. You must continue to pay all applicable charges for these services:

- Professional services of physicians:
 - In physician’s office
 - In an urgent care center
 - Office medical consultations
 - Second surgical opinion
- Prescription drugs
- Dental services
- Services of non-Plan providers
- Diagnosis and treatment of infertility
- Surgical treatment of morbid obesity
- Diagnosis and treatment of sleep disorders

Right of Recovery

We will make diligent efforts to recover benefit payments we made in good faith but in error. We shall have the right to recover the excess payment amount from you, from your provider, or from another plan, as applicable.

Section 5. Benefits – OVERVIEW

(See page 9 for how our benefits changed this year and page 75 for a benefits summary.)

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699; or visit our Web site at www.kpshealthplans.com.

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• Neurodevelopmental therapies	
• Physical and occupational therapies	
• Speech therapy	
• Hearing services (testing, treatment and supplies)	
• Vision services (testing, treatment and supplies)	
• Foot care	
• Orthopedic and prosthetic devices	
• Durable medical equipment (DME)	
• Home health services	
• Chiropractic	
• Alternative treatments	
• Educational classes and programs	
• Sleep disorders	
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Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option – We have no calendar year deductible.**
- **Under Standard Option –** The calendar year deductible is \$350 per person (\$700 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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **For the non-Plan provider benefit see Section 5(i), Point-of-Service (POS) benefits, page 53.**

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Benefit Description	You pay	
Diagnostic and treatment services	You pay – High Option	You pay – Standard Option
Professional services of physicians <ul style="list-style-type: none"> • In a physician’s office • In an urgent care center • Office medical consultations • Second surgical opinion Note: You pay a copayment for office visits billed with codes corresponding to these services. All other services are subject to the coinsurance or benefit limitations as referenced in this brochure.	\$15 copayment for primary care \$25 copayment for specialty care Primary care providers are family practitioners, general practitioners, obstetricians/gynecologists, pediatricians, naturopaths, physician assistants (under the supervision of a physician), or advanced registered nurse practitioners (ARNPs).	\$15 copayment (no deductible) per visit for first three (3) professional office visits (first 3 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits Example: <ul style="list-style-type: none"> • Your first visit of the year is with a primary care doctor; you pay \$15. • Your second visit of the year is with a chiropractor; you pay \$15. • Your third visit of the year is with a physical therapist; you pay \$15. • Starting with your fourth professional office visit, and for all additional office visits, you will pay the applicable deductible and 20% coinsurance.
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility • Initial exam of a newborn child covered under a family enrollment 	20%	20%

Diagnostic & treatment services – continued on next page

Diagnostic and treatment services (cont'd)	You pay – High Option	You pay – Standard Option
At home	20%	20%
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
<ul style="list-style-type: none"> • Non-surgical treatment of morbid obesity 		
Lab, X-ray and other diagnostic tests		
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG 	20%	20%
Preventive care, adult		
Routine screenings, such as: <ul style="list-style-type: none"> • Complete Blood Count, one annually • Total Blood Cholesterol, once every 3 years • A fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides) once every 5 years for adults 20 or over • Colorectal cancer screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, once every 5 years starting at age 50; or – Colonoscopy, once every 10 years starting at age 50; or – Double contrast barium enema (DCBE), once every 5-10 years starting at age 50 • Routine osteoporosis screening for women age 65 and older; beginning at age 60 for women at increased risk • Routine Prostate Specific Antigen (PSA) test, one annually for men age 40 and older • Routine pap test Note: The office visit is covered if pap test is received on the same day; if not see <i>Diagnosis and Treatment</i> , above.	\$15 Copayment	Nothing up to \$500 combined annual maximum for preventive care allowable charges. Once \$500 maximum is reached, you pay all additional charges. No deductible

Preventive care, adult – continued on next page

Preventive care, adult <i>(continued)</i>	You pay – High Option	You pay – Standard Option
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <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 mammograms, mammograms are covered when prescribed by the doctor as necessary to diagnosis or treat your illness.</p>	20%	<p>Nothing up to \$500 combined annual maximum for preventive care allowable charges.</p> <p>Once \$500 maximum is reached, you pay all additional charges.</p> <p>No deductible</p>
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel</i></p>	<i>All charges</i>	<i>All charges</i>
<p>Routine immunizations, limited to:</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, age 65 & over Pneumococcal vaccines, age 65 & over 	Nothing	Nothing
Preventive care, children		
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics Well-child care charges for routine examinations, immunizations and care (through age 21) 	Nothing	<p>Nothing up to \$500 combined annual maximum for preventive care allowable charges.</p> <p>Once \$500 maximum is reached, you pay all additional charges.</p> <p>No deductible</p>
<ul style="list-style-type: none"> Examinations, such as: <ul style="list-style-type: none"> Screening eye exams through age 17 to determine the need for vision correction Screening ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (through age 21) 	\$15 copayment per exam	<p>20%</p> <p>No deductible</p>

Family planning	You pay – High Option	You pay – Standard Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (see Section 5(b), <i>Surgical procedures</i>) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	20%	20%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic testing</i> • <i>Abortions including drugs and 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</i> 	<i>All charges</i>	<i>All charges</i>
Infertility services		
<p>Diagnosis & treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – <i>Intravaginal insemination (IVI)</i> – <i>Intra-cervical insemination (ICI)</i> 	50%	50%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>In vitro fertilization</i> – <i>Embryo transfer, gamete GIFT and zygote ZIFT</i> – <i>Zygote transfer</i> – <i>Intrauterine insemination (IUI)</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Fertility drugs</i> 	<i>All charges</i>	<i>All charges</i>
Allergy care		
<p>Testing and treatment Allergy injection</p>	20%	20%

Allergy care – continued on next page

Allergy care (continued)	You pay – High Option	You pay – Standard Option
Allergy serum	Nothing	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>	<i>All charges</i>
Treatment therapies		
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Section 5(b), <i>Organ/Tissue Transplants</i>.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy. Pre-authorization required • Growth hormone therapy (GHT) <p>Note: GHT is covered under the prescription drug benefit.</p> <p>We will only cover GHT when we pre-authorize the treatment. It is covered under your pharmacy benefit. Call MedImpact at 800-788-2949 for pre-authorization. They will ask you to submit information that establishes that GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover GHT or related services and supplies.</p> <p>See <i>Services requiring our prior approval</i> in Section 3.</p>	20%	20%
Neurodevelopmental therapies		
<p>Coverage under this benefit for the restoration and improvement of function in a neurodevelopmentally disabled Child who is six (6) years of age or younger includes:</p> <ul style="list-style-type: none"> • Inpatient and outpatient physical, speech and occupational therapy; and • Ongoing maintenance care in cases where significant deterioration of the Child's condition would occur without the care. <p>All therapy treatments must be performed by a physician, registered physical therapist (PT), ASHA-certified speech therapist or an occupational therapist certified by the American Occupational Therapy Association.</p> <p>No coverage is provided under this benefit for any person who is age seven (7) or older.</p> <p>Coverage under this benefit does not duplicate coverage for therapy services provided under any other benefit of this Plan.</p>	20%	20%

Physical and occupational therapies	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> Up to 60 visits per year combined for speech therapy (see below) and for the services of the following: <ul style="list-style-type: none"> – Qualified physical therapists – Occupational therapists – Licensed massage therapists (when prescribed by a primary care physician) <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p>	20%	\$15 copayment (no deductible) per visit for first three (3) professional office visits (first 3 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits
<ul style="list-style-type: none"> Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to \$500 	20%	20%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<i>All charges</i>	<i>All charges</i>
Speech therapy		
<ul style="list-style-type: none"> Licensed speech therapist <p>Note: Speech therapy is combined with 60 visits per year for the services of physical therapy and/or occupational therapy (see above)</p>	20%	\$15 copayment (no deductible) per visit for first three (3) professional office visits (first 3 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits
Hearing services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> Hearing tests for children through age 17 (see <i>Preventive care, children</i>) 	20%	20% No deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing & examinations for them 	<i>All charges</i>	<i>All charges</i>

Vision services (testing, treatment, and supplies)	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	20%	20%
<ul style="list-style-type: none"> Annual eye exam - adult 	\$15 copayment	20%
<ul style="list-style-type: none"> Eye exams to determine the need for vision correction for children through age 17 (see Section 5(a), <i>Preventive care-children</i>) 	\$15 copayment per exam	20% No deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Additional eyeglasses or contacts</i> <i>Eye exercises and orthoptics</i> <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>	<i>All charges</i>
Foot care		
<ul style="list-style-type: none"> Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. <p>See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	20%	20%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>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</i> <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges</i>	<i>All charges</i>
Orthopedic and prosthetic devices		
<ul style="list-style-type: none"> Artificial limbs and eyes; stump hose 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%	20%

Orthopedic and prosthetic devices – continued on next page

Orthopedic and prosthetic devices <i>(continued)</i>	You pay – High Option	You pay – Standard Option
<p>Note: This benefit combined with the <i>Durable Medical Benefit</i> is limited to a maximum Plan payment of \$2,500 per calendar year and \$10,000 maximum per lifetime</p> <ul style="list-style-type: none"> • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. <p>Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See Section 5(b) for coverage of the surgery to insert the device.</p>	20%	20%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Cochlear implants</i> • <i>Prosthetic replacements provided less than 3 years after the last one we covered</i> 	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)		
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors • Insulin pumps • Motorized wheel chairs <p>Note: This list is not complete. For more details please contact Member Services at 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699</p> <p>Note: This benefit combined with the <i>Orthopedic and prosthetic devices</i> benefit is limited to a maximum payment of \$2,500 per calendar year and \$10,000 maximum per lifetime.</p>	20%	20%

Durable medical equipment – continued on next page

Durable medical equipment (DME) <i>- continued</i>	You pay – High Option	You pay – Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Exercise equipment such as Nordic Track and/or exercise bicycles</i> • <i>Equipment which is primarily used for non-medical purposes such as hot tubs and massage pillows</i> • <i>Convenience items</i> 	<i>All charges</i>	<i>All charges</i>
Home health services		
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.); licensed practical nurse (L.P.N.); licensed vocational nurse (L.V.N.); master of social work (M.S.W.) or home health aide. Up to two hours per visit. • Services include oxygen therapy, intravenous therapy and medications. <p>Note: These services require pre-certification. Please refer to the pre-certification information shown in Section 3.</p> <p>Note: Therapy (physical, occupational, speech) applies towards your therapy maximum of 60 visits per calendar year.</p>	\$15 copayment per visit	20% per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> 	<i>All charges</i>	<i>All charges</i>
Chiropractic		
<ul style="list-style-type: none"> • Up to 18 treatments per calendar year for manipulation of the spine and extremities 	\$15 copayment per treatment	\$15 copayment (no deductible) per visit for first three (3) professional office visits (first 3 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy and cold pack application.</i> 	<i>All charges</i>	<i>All charges</i>

Alternative treatments	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> Acupuncture – up to 18 treatments per calendar year when treatment is received by a licensed Plan provider 	\$15 copayment per treatment	\$15 copayment (no deductible) per visit for first three (3) professional office visits (first 3 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits
<i>Not covered:</i> <ul style="list-style-type: none"> Herbs prescribed by an acupuncturist or naturopath Hypnotherapy Biofeedback 	<i>All charges</i>	<i>All charges</i>
Educational classes and programs		
Coverage is limited to: <ul style="list-style-type: none"> Smoking Cessation – Up to \$150 for one smoking cessation program per member per lifetime. Approved medications obtained at a Plan pharmacy will be covered under the <i>Prescription Drug Benefit</i> to a lifetime maximum of \$350 per member. 	\$15 copayment for office visit	20% No deductible
<ul style="list-style-type: none"> Outpatient nutritional guidance counseling services by a registered dietitian for the following conditions: <ul style="list-style-type: none"> Diabetes Cancer Endocrine conditions Swallowing conditions after stroke Hyperlipidemia Colitis Coronary artery disease Dysphagia Gastritis Inactive colon Anorexia Bulimia Short bowel syndrome (post surgery) Food allergies or intolerances Up to \$400 maximum per member per year.	20%	20% No deductible
<i>Not covered:</i> <ul style="list-style-type: none"> Over-the-counter drugs 	<i>All charges</i>	<i>All charges</i>

Sleep disorders	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> • Sleep studies - Coverage under this benefit is limited to sleep studies, including provider services, appropriate durable medical equipment, and surgical treatments. No other benefits for the purpose of studying, monitoring and/or treating sleep disorders, other than as described below, is provided. Sleep studies are limited to a lifetime maximum of \$5,000. <p>Coverage for sleep studies includes:</p> <ul style="list-style-type: none"> • Polysomnographs • Multiple sleep latency tests • Continuous positive airway pressure (CPAP) studies • Related durable medical equipment and supplies, including CPAP machines <p>The condition giving rise to the sleep disorder (such as narcolepsy or sleep apnea) must be diagnosed by the patient's Provider. Pre-authorization of sleep studies is not required, however, the patient must be referred to the sleep studies program by his/her Provider.</p> <ul style="list-style-type: none"> • Surgical treatment – of the above listed sleep disorders will be limited to a lifetime maximum of \$3,000. 	50%	50%
<p>Coverage for the medically necessary surgical treatment of diagnosed sleep disorders is covered under this benefit. Pre-authorization of surgical procedures for the treatment of sleep disorders is required. Surgical treatment includes all professional and facility fees related to the surgical treatment including pre- & post-operative care and complications.</p>		
<p><i>Not covered: Any service not listed above for the purpose of studying, monitoring and/or treating sleep disorders.</i></p>	<i>All charges</i>	<i>All charges</i>
<p>Temporomandibular joint (TMJ) disorders</p>		
<p>Treatment of TMJ, including surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy</p>	20%	20%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services primarily for cosmetic purposes</i> • <i>Related dental work</i> 	<i>All charges</i>	<i>All charges</i>

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option there is no deductible for these services.**
- **Under Standard Option** the calendar year deductible is \$350 per person (\$700 per family). The calendar year deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing 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 charge (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRE-CERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the pre-certification information shown in Section 3 to be sure which services require pre-certification and identify which surgeries require pre-certification.
- **For non-Plan provider benefit see Section 5(i), Point-of-Service (POS) benefits, page 53.**

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Benefit Description	You pay	
Surgical procedures	You pay – High Option	You pay – 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 • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices • Circumcision from birth to one month old or as medically necessary 	20%	20%
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over 	50%	50%

Surgical procedures – continued on next page

Surgical procedures <i>(continued)</i>	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay <i>Hospital benefits</i> for a pacemaker and <i>Surgery benefits</i> for insertion of the pacemaker.</p>	20%	20%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot</i> (see Section 5(a), <i>Foot care</i>) 	<i>All charges</i>	<i>All charges</i>
Reconstructive surgery		
<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 • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • 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 – Breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>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>	20%	20%
<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, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>	<i>All charges</i>

Oral and maxillofacial surgery	You pay – High Option	You pay – 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; and • Other surgical procedures that do not involve the teeth or their supporting structures 	20%	20%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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>All charges</i>	<i>All charges</i>
Organ/tissue transplants		
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Pancreas • Liver • Lung: Single –Double • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. Limited to those transplants that meet our protocols. 	20%	20%

Organ/tissue transplant - continued on next page

Organ/tissue transplants <i>(cont'd)</i>	You Pay – High Option	You Pay – Standard Option
<p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI or NIH approved clinical trial at a Plan-designated center of excellence and if approved by our medical director in accordance with our protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	20%	20%
<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 artificial organs</i> • <i>Any transplant not specifically listed as a covered benefit</i> 	<i>All charges</i>	<i>All charges</i>
Anesthesia		
<p>Professional services provided in</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	20%	20%

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

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Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option there is no deductible for these services.**
- **Under Standard Option** the calendar year deductible of \$350 per person (\$700 per family) applies to all these services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- 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 Section 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRE-CERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which **services require pre-certification.**
- **For non-Plan provider benefit see Section 5(i), Point-of-Service (POS) benefits, page 53.**

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Benefit Description	You pay	
Inpatient hospital	You pay – High Option	You pay – Standard Option
Room and board, such as: <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • 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.	20%	20% - Subject to \$100 per day copayment to \$500 maximum per admission.
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 • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Private nursing care 	20%	20%

Inpatient hospital – continued on next page

Inpatient hospital (continued)	You pay – High Option	You pay – Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care rest cures, domiciliary or convalescent care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Take home medications</i> 	<i>All charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center		
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • 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 • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	20%	20%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Blood and blood derivatives not replaced by the member</i> • <i>Take home medications</i> 	<i>All charges</i>	<i>All charges</i>
Extended care benefits/skilled nursing care facility benefits		
<p>Extended care benefit: We cover a comprehensive range of benefits with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by us. Extended care benefits require pre-authorization by our medical director.</p>	20%	20%
<i>Not covered: Custodial care</i>	<i>All charges</i>	<i>All charges</i>

Hospice care	You pay – High Option	You pay – Standard Option
<p>Supportive and palliative care for a terminally ill member is covered in the home up to a \$5,000 maximum Plan payment per member per calendar year.</p> <p>Services include</p> <ul style="list-style-type: none"> • Medical care • Family counseling <p>Inpatient hospice benefits are provided for up to five (5) consecutive days in a hospital or a freestanding hospice inpatient facility.</p> <p>Each inpatient stay must be separated by at least 21 days.</p> <p>These covered inpatient hospice benefits are available only when inpatient services are necessary to:</p> <ul style="list-style-type: none"> • Control pain and manage the patient’s symptoms; or • Provide an interval of relief (respite) to the family. <p>Note: Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	20%	20%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing</i> • <i>Homemaker services</i> 	<i>All charges</i>	<i>All charges</i>
Ambulance		
<p>Coverage for ambulance services includes:</p> <ul style="list-style-type: none"> • Ground transportation • Air transportation up to \$5,000 per trip <p>Air ambulance transportation is subject to review and approval by KPS. In cases where the patient's condition does not warrant air transportation, coverage will be based on the benefit for ground transportation.</p> <p>Note: If you are hospitalized in a non-Plan facility and Plan doctors believe care can be provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.</p>	20%	20%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>The use of any type of ambulance transportation for personal convenience</i> 	<i>All charges</i>	<i>All charges</i>

Section 5 (d). Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option there is no deductible for these services.**
- **Under Standard Option** the calendar year deductible is \$350 per person (\$700 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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are enrolled with us so they can notify us. You or a family member should notify us within 48 hours. It is your responsibility to ensure that we have been notified in a timely manner.

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

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

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

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

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

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

Benefit Description	You pay	
Emergency within our service area	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> Emergency care at a doctor's office Emergency care at an urgent care center 	\$15 office visit copayment	\$15 copayment (no deductible) per visit for first three (3) professional office visits (first 3 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits
<ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services <p>Note: Under High Option, if the emergency results in admission to a hospital, inpatient services are subject to the hospital admission coinsurance of 20% and the emergency care copay is waived.</p>	\$75 copayment	20%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> 	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area		
<ul style="list-style-type: none"> Emergency care at a doctor's office Emergency care at an urgent care center 	\$15 office visit copayment	\$15 copayment (no deductible) per visit for first three (3) professional office visits (first 3 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits
<ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services <p>Note: Under High Option, if the emergency results in admission to a hospital, inpatient services are subject to the hospital admission coinsurance of 20% and the emergency care copay is waived.</p>	\$75 copayment	20%
<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>All charges</i>	<i>All charges</i>

Ambulance	You pay – High Option	You pay – Standard Option
<p>Professional ambulance service when medically appropriate</p> <ul style="list-style-type: none"> • Ground transportation • Air transportation up to \$5,000 per trip <p>In cases where the patient's condition does not warrant air transportation, coverage will be based on the benefit for ground transportation.</p> <p>Note: If you are hospitalized in a non-Plan facility and Plan doctors believe care can be provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.</p> <p>See Section 5(c), for non-emergency service.</p>	20%	20%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>The use of any type of ambulance transportation for personal convenience is not covered under this benefit</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.

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option there is no deductible for these services.**
- **Under Standard Option** the calendar year deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRE-AUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.
- **For non-Plan provider benefit see Section 5(i), Point-of-Service (POS) benefits, page 53.**

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Benefit Description	You pay	
Mental health and substance abuse benefits	You pay – High Option	You pay – Standard Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$15 office visit copayment</p>	<p>\$15 copayment (no deductible) per visit for first three (3) professional office visits (first 3 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits)</p> <p>Deductible and 20% coinsurance apply for all subsequent visits</p>

Mental health and substance abuse benefits – continued on next page

Mental health and substance abuse benefits <i>(continued)</i>	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> Diagnostic tests 	20%	20%
<ul style="list-style-type: none"> Services provided by a hospital or other facility Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	20%	20%
<p><i>Not covered: Services we have not approved</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges</i>	<i>All charges</i>

Pre-authorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

All inpatient stays and outpatient visits must be pre-authorized by the Plan. You or your mental health or substance abuse provider must obtain pre-authorization by calling 800-223-6114 before services are provided. **If pre-authorization is not obtained, payment for the services will be denied.**

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

Pre-authorization for mental health and substance abuse services is required at the beginning of each new contract year, regardless if the care is on-going.

Limitation

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

Section 5 (f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on page 45.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no calendar year deductible for this benefit.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy. The Point-of-Service (POS) benefit does not apply to prescriptions filled at a non-Plan pharmacy except for out-of-area emergencies.

Mail Order Program

All prescriptions are available through the Walgreens Pharmacy mail order program. Prescriptions ordered through this program are subject to the same copayments, guidelines and limitations set forth above.

For questions regarding this mail order program, contact Walgreens Customer Service at toll-free 800-345-1985 available Monday through Friday, 7:00 a.m. to 7:00 p.m. (Mountain time) or Saturday, 7:00 a.m. to noon (Mountain time).

Order forms are available through KPS Member Services by calling 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699.

Mail your order to:

Walgreens Healthcare Plus
P.O. Box 29061
Phoenix, AZ 85038-9061

- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 31-day supply (except certain maintenance drugs approved by the Plan may be dispensed on a 3-month supply basis). The Plan determines which drugs are covered as maintenance drugs. Maintenance drugs will be subject to 2 copayments for a 3-month supply except for drugs not covered as maintenance drugs or any Tier 3 drugs. If a drug is not categorized as “maintenance” or is a Tier 3 drug, you will pay the applicable copayment or coinsurance.

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

Under the following circumstances, please contact our pharmacy benefit management company, MedImpact, at toll free 1-800-788-2949:

- To obtain a medium-term supply of medications if you are called to active military duty
- To obtain a short-term supply of medications in times of national or other emergencies
- **We have an open formulary.** This means we classify ALL drugs (see page 44 for a list of specific diagnoses with medications that must be ordered through Bio Scripts only) into one of three “tier” categories:
 - Tier 1 drugs, generally generic, have the lowest associated copayment
 - Tier 2 drugs, also called ‘preferred drugs’, have a slightly higher copayment
 - Tier 3 drugs, also known as ‘non-preferred’ drugs, are all other drugs that are not on our drug list; Tier 3 drugs have the highest copayment

Prescription drug information – continued on next page

Because of their lower cost to you, we recommend that you ask your provider to prescribe Tier 1 or Tier 2 ('preferred') drugs rather than Tier 3 ('non-preferred') drugs. To order a prescription drug list, call us at 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699. You may also access the prescription drug list on our Web site at: www.kpshealthplans.com.

Preferred drug means a branded, single source agent or generic drug that has been determined as preferred by us.

Non-preferred drug means a branded, single source agent or generic drug that has been determined as non-preferred by us.

Note: The drug list is continually reviewed and revised. We reserve the right to update this list at any time. For the most up-to-date information about the drug list, visit our Web site at www.kpshealthplans.com.

- **Why use Generic Drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.
- **When you have to file a claim.** When you use a Plan pharmacy, you will not be responsible for submitting a claim form to the Plan. In the event of an accidental injury or medical emergency, you may utilize the services of a non-Plan pharmacy. For reimbursement, please submit an itemized claim form to: MedImpact, 10680 Treena Street, 5th floor, San Diego, CA 92131.
- **For additional information,** call MedImpact (the pharmacy benefit company that administers our prescription drug benefit) at toll free 1-800-788-2949.
- **Bio Scrip medications.** Certain diagnoses require medications that your physician must order for you only through Bio Scrip. The following is a list of those diagnoses and medications:

<u>Hepatitis C</u>	<u>Growth Hormone</u>	<u>Rhumetoid Arthritis</u>	<u>Multiple Sclerosis</u>
PEGASYS	Genotropin	Rebif	Avonex
Peg-Intron	Protropin	Enbrel	Betaseron
Intron A	Nutropin	Humira	Copaxone
Rebetron	Nutropin AQ		
Infergen	Nutropin Depot Kit		
Rofeon A	Siazen		
Rebetol	Humatrope		
Copegus			

Prescription drug benefits begin on the next page

Benefit Description	You pay	
Covered medications and supplies	You pay – High Option	You pay – Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy.</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 those listed as <i>Not covered</i> • Insulin, with a copay/coinsurance charge applied to each vial • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction to an annual maximum plan payment of \$500 per member • Contraceptive drugs and devices • Growth hormones • Prenatal vitamins during pregnancy • Smoking cessation medications up to a lifetime maximum of \$350 per member 	<p><u>Tier 1-Generic</u> \$5 per prescription/refill</p> <p><u>Tier 2-Preferred Brand</u> \$20 per prescription/refill</p> <p><u>Tier 3-Non-Preferred Brand</u> \$100 or 50% whichever costs the member less per prescription/refill</p>	<p><u>Tier 1-Generic</u> \$10 per prescription/refill.</p> <p><u>Tier 2-Preferred Brand</u> \$30 per prescription/refill</p> <p><u>Tier 3-Non-Preferred Brand</u> 50% with \$40 minimum prescription price</p>
	<p>With Medicare A & B Primary You pay – High Option</p>	<p>With Medicare A & B Primary You pay – Standard Option</p>
	<p><u>Tier 1-Generic</u> \$3 per prescription/refill</p> <p><u>Tier 2-Preferred Brand</u> \$12 per prescription/refill</p> <p><u>Tier 3-Non-Preferred Brand</u> \$100 or 50% whichever costs the member less per prescription/refill</p>	<p><u>Tier 1-Generic</u> \$10 per prescription/refill.</p> <p><u>Tier 2-Preferred Brand</u> \$30 per prescription/refill</p> <p><u>Tier 3-Non-Preferred Brand</u> 50% with \$40 minimum prescription price</p>

Covered medications and supplies – continued on next page

Covered medications and supplies <i>(continued)</i>	You pay – High Option	You pay – Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Non-prenatal vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines (except certain over-the-counter substances approved by the Plan)</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Fertility drugs</i> • <i>Drugs to enhance athletic performance</i> • <i>Implanted time-release medications (except those used for contraception)</i> • <i>Drugs prescribed to treat any non-covered service</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Compounded drugs for hormone replacement therapy</i> • <i>Drugs that are not medically necessary according to accepted medical, dental or psychiatric practice as determined by the Plan</i> • <i>Smoking cessation over-the-counter drugs</i> 	<i>All charges</i>	<i>All charges</i>

Section 5 (g). Special features

Feature	Description
<p>Flexible benefits option</p>	<p>In certain cases, KPS, at its sole discretion, may choose to authorize coverage for benefits or services that are not otherwise included as covered under this Plan. Such authorization is done on a case-by-case basis if a particular benefit or service is judged to be medically necessary, beneficial and cost effective. However, our decision to authorize services in one instance does not commit us to cover the same or similar services for you in other instances, or to cover the same or similar services in any other instance for any other enrollee. Our decision to authorize services does not constitute a waiver of our right to enforce the provisions, limitations and exclusions of this Plan.</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 benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
<p>Travel benefit/services overseas</p>	<p>See Section 5(d) for emergency/urgently needed care benefit details</p> <p>For emergency or urgently needed care received outside the United States:</p> <ul style="list-style-type: none"> • Send itemized authentic bills/receipts that include an English translation to: <ul style="list-style-type: none"> <li style="margin-left: 40px;">KPS Health Plans <li style="margin-left: 40px;">Attn: Member Services <li style="margin-left: 40px;">PO Box 339 <li style="margin-left: 40px;">Bremerton, WA 98337 • If it is for prescription drugs, the bill/receipt must list the name of the drug and the amount of pills for each prescription • Convert charges to U.S. dollars using the exchange rate applicable at the time the expense was incurred • If possible, include a receipt showing the exchange rate on the date the claimed services were performed • Provide proof of travel (airline ticket, passport, etc)

Section 5 (h). Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible of \$25 per member (\$50 maximum per family) is required for the services listed under “Basic dental care”.
- **The calendar year maximum for all services combined is \$1,000 per member.**
- After you have satisfied your annual deductible, **we pay 100% of the Fee Schedule Allowance for each procedure listed.** You are responsible for any amounts billed by your dentist that are greater than the KPS Fee Schedule Allowance.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5 (c) for inpatient hospital benefits.
- The dental procedures listed below are not all-inclusive and are subject to change. Please call us at 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699 for additions/changes to the list of covered American Dental Association (ADA) codes.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Accidental injury benefit	You pay High Option	You pay Standard Option																																				
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. Sound natural teeth are those that do not have any restoration. The need for these services must result from an accidental injury (not biting or chewing). All services must be performed and completed within 12 months of the date of injury.	20%	20%																																				
Dental benefits	You pay High Option	You pay Standard Option																																				
<p>Preventive dental care</p> <ul style="list-style-type: none"> • Diagnostic <p>Full mouth or panorex X-rays – once every 3 calendar years</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Panoramic film</td> <td style="text-align: center;">D0330</td> <td style="text-align: center;">\$77.00</td> </tr> <tr> <td>Intraoral - complete series (including bitewings)</td> <td style="text-align: center;">D0210</td> <td style="text-align: center;">\$95.00</td> </tr> <tr> <td>Intraoral – periapical first film</td> <td style="text-align: center;">D0220</td> <td style="text-align: center;">\$20.00</td> </tr> <tr> <td>Intraoral – periapical each additional film</td> <td style="text-align: center;">D0230</td> <td style="text-align: center;">\$19.00</td> </tr> <tr> <td>Intraoral – occlusal film</td> <td style="text-align: center;">D0240</td> <td style="text-align: center;">\$41.00</td> </tr> </table> <p>Bitewing X-rays – twice per calendar year</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Bitewing – single film</td> <td style="text-align: center;">D0270</td> <td style="text-align: center;">\$20.00</td> </tr> <tr> <td>Bitewings – two films</td> <td style="text-align: center;">D0272</td> <td style="text-align: center;">\$31.00</td> </tr> <tr> <td>Bitewings – four films</td> <td style="text-align: center;">D0274</td> <td style="text-align: center;">\$45.00</td> </tr> </table> <p>Oral exam – once each 6-month period</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Periodic oral exam</td> <td style="text-align: center;">D0120</td> <td style="text-align: center;">\$41.00</td> </tr> <tr> <td>Limited oral evaluation – problem focused</td> <td style="text-align: center;">D0140</td> <td style="text-align: center;">\$58.00</td> </tr> <tr> <td>Comprehensive oral evaluation</td> <td style="text-align: center;">D0150</td> <td style="text-align: center;">\$57.00</td> </tr> <tr> <td>Pulp vitality tests</td> <td style="text-align: center;">D0460</td> <td style="text-align: center;">\$42.00</td> </tr> </table> <p>Emergency examinations – as determined by the Plan</p>	Panoramic film	D0330	\$77.00	Intraoral - complete series (including bitewings)	D0210	\$95.00	Intraoral – periapical first film	D0220	\$20.00	Intraoral – periapical each additional film	D0230	\$19.00	Intraoral – occlusal film	D0240	\$41.00	Bitewing – single film	D0270	\$20.00	Bitewings – two films	D0272	\$31.00	Bitewings – four films	D0274	\$45.00	Periodic oral exam	D0120	\$41.00	Limited oral evaluation – problem focused	D0140	\$58.00	Comprehensive oral evaluation	D0150	\$57.00	Pulp vitality tests	D0460	\$42.00	<p>You pay all charges in excess of our scheduled allowance shown below: (No deductible for preventive care)</p>	
Panoramic film	D0330	\$77.00																																				
Intraoral - complete series (including bitewings)	D0210	\$95.00																																				
Intraoral – periapical first film	D0220	\$20.00																																				
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Bitewing – single film	D0270	\$20.00																																				
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Comprehensive oral evaluation	D0150	\$57.00																																				
Pulp vitality tests	D0460	\$42.00																																				

Dental benefits – continued on next page

Dental benefits <i>(continued)</i>	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> Preventive <ul style="list-style-type: none"> Prophylaxis (cleaning) – once each 6-month period <ul style="list-style-type: none"> Prophylaxis – through age 13 D1120 Prophylaxis – after age 13 D1110 Fluoride – once each 6-month period through age 17 <ul style="list-style-type: none"> Topical application of fluoride (including prophylaxis) – through age 13 D1201 Topical application of fluoride (including prophylaxis) – after age 13 D1205 Topical application of fluoride (prophylaxis not included) – through age 13 D1203 Topical application of fluoride (prophylaxis not included) – after age 13 D1204 	<p>You pay all charges in excess of our scheduled allowance shown below: (No deductible for preventive care)</p>	
<p>Basic dental care</p> <ul style="list-style-type: none"> Restorative <ul style="list-style-type: none"> Restoration of carious (decayed) teeth to a state of functional acceptability utilizing filling materials, such as amalgam, silicate or plastic <ul style="list-style-type: none"> Amalgam restorations (including polishing) <ul style="list-style-type: none"> Amalgam – one surface, primary D2110 Amalgam – two surfaces, primary D2120 Amalgam – three surfaces, primary D2130 Amalgam – four or more surfaces, primary D2131 Amalgam – one surface, permanent D2140 Amalgam – two surfaces, permanent D2150 Amalgam – three surfaces, permanent D2160 Amalgam – four or more surfaces, permanent D2161 Resin-based composite restorations <ul style="list-style-type: none"> Resin-based composite – one surface, anterior D2330 Resin-based composite – two surfaces, anterior D2331 Resin-based composite – three surfaces, anterior D2332 Resin-based composite – four or more surfaces or involving incisal angle (anterior) D2335 Resin-based composite – one surface, posterior-primary D2380 Resin-based composite – two surfaces, posterior-primary D2381 Resin-based composite – three or more surfaces, posterior-primary D2382 Resin-based composite – one surface, posterior-permanent D2385 Resin-based composite – two surfaces, posterior-permanent D2386 Resin-based composite – three surfaces, posterior-permanent D2387 Other restorative services <ul style="list-style-type: none"> Sedative filling D2940 		<p>You pay all charges in excess of the scheduled allowance shown below after your deductible has been satisfied:</p>

Dental benefits – continued on next page

Dental benefits (continued)	You pay High Option	You pay Standard Option
Application of sealants for permanent molars and bicuspid only (with a 3 year limitation per surface) through age 13.	You pay all charges in excess of the scheduled allowance shown below after your deductible has been satisfied:	No benefit
Sealant – per tooth	D1351	\$28.00
<ul style="list-style-type: none"> Oral Surgery 		
Removal of teeth and minor surgical procedures, including surgical and non-surgical extractions, preparation of the alveolar ridge and soft tissues of the mouth for insertion of dentures and general anesthesia when administered in connection with covered oral surgery procedures.		
Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care)		
Single tooth (uncomplicated)	D7110	\$87.00
Each additional tooth (uncomplicated)	D7120	\$80.00
Root removal – exposed roots	D7130	\$128.00
Surgical Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care)		
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	D7210	\$199.00
Removal of impacted tooth – soft tissue	D7220	\$261.00
Removal of impacted tooth – partially bony	D7230	\$273.00
Removal of impacted tooth – completely bony	D7240	\$289.00
Removal of impacted tooth – completely bony, with unusual surgical complications	D7241	\$342.00
Surgical removal of residual tooth roots (cutting procedure)	D7250	\$178.00
Alveoloplasty – surgical preparation of the ridge for dentures		
Alveoloplasty in conjunction with extractions – per quadrant	D7310	\$141.00
Excision of bone tissue		
Removal of exostosis – per site	D7471	\$753.00
Surgical Incision		
Incision and drainage of abscess – intraoral soft tissue	D7510	\$187.00
<ul style="list-style-type: none"> Periodontics 		
Surgical and non-surgical procedures for treatment of the tissues supporting the teeth, including root planing, subgingival curettage, gingivectomy and minor adjustments to occlusion such as smoothing of teeth or reducing cusps.		
Surgical services (including usual post-operative care)		
Gingivectomy or gingivoplasty – per quadrant	D4210	\$472.00
Gingivectomy or gingivoplasty – per tooth	D4211	\$127.00
Gingival curettage, surgical – per quadrant, by report	D4220	\$168.00
Gingival flap procedure, including root planing – per quadrant	D4240	\$419.00
Clinical crown lengthening – hard tissue	D4249	\$647.00

Dental benefits – continued on next page

Dental benefits (continued)	You pay High Option	You pay Standard Option
	You pay all charges in excess of the scheduled allowance shown below after your deductible has been satisfied:	No benefit
Osseous surgery (including flap entry & closure) per quadrant D4260	\$830.00	
Bone replacement graft – first site in quadrant D4263	\$385.00	
Bone replacement graft – each additional site in quadrant D4264	\$182.00	
Pedicle soft tissue graft procedure D4270	\$664.00	
Free soft tissue graft procedure (including donor site surgery) D4271	\$491.00	
Subepithelial connective tissue graft procedure (including donor site surgery) D4273	\$728.00	
Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) D4274	\$206.00	
Non-Surgical Periodontal Service		
Periodontal scaling and root planing, per quadrant D4341	\$131.00	
Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis D4355	\$109.00	
Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report D4381	\$71.00	
Other Periodontal Services		
Periodontal maintenance procedures (following active therapy) D4910	\$106.00	
• Endodontics		
Procedures for pulpal and root canal therapy, including pulp exposure treatment, pulpotomy and apicoectomy		
Pulp Capping		
Pulp cap – direct (excluding final restoration) D3110	\$60.00	
Pulp cap – indirect (excluding final restoration) D3120	\$39.00	
Pulpotomy		
Therapeutic pulpotomy (excluding final restoration) D3220	\$82.00	
Endodontic Therapy on Primary Teeth		
Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) D3240	\$127.00	
Endodontic Therapy (including treatment plan, clinical procedures and follow-up care)		
Anterior (excluding final restoration) D3310	\$495.00	
Bicuspid (excluding final restoration) D3320	\$525.00	
Molar (excluding final restoration) D3330	\$706.00	
Apicoectomy/Periradicular Services		
Apicoectomy/periradicular surgery – anterior D3410	\$540.00	
Apicoectomy/periradicular surgery – bicuspid (first root) D3421	\$762.00	
Apicoectomy/periradicular surgery – molar (first root) D3425	\$667.00	
Apicoectomy/periradicular surgery (each additional root) D3426	\$222.00	
Retrograde filling - per root D3430	\$163.00	

Dental benefits – continued on next page

Dental benefits <i>(continued)</i>	You pay High Option	You pay Standard Option						
<ul style="list-style-type: none"> • Pedodontics <p style="margin-left: 40px;">Space maintainers when used to maintain space only.</p> <table border="1" style="margin-left: 40px; width: 100%;"> <tr> <td style="width: 60%;">Fixed – unilateral type</td> <td style="width: 20%;">D1510</td> <td style="width: 20%;">\$192.00</td> </tr> <tr> <td>Fixed – bilateral type</td> <td>D1515</td> <td>\$320.00</td> </tr> </table>	Fixed – unilateral type	D1510	\$192.00	Fixed – bilateral type	D1515	\$320.00	<p>You pay all charges in excess of the scheduled allowance shown below after your deductible has been satisfied:</p>	<p>No benefit</p>
Fixed – unilateral type	D1510	\$192.00						
Fixed – bilateral type	D1515	\$320.00						
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Appliances or restorations necessary to correct vertical dimensions or restore the occlusion • Crowns (includes temporary crowns) • Restoration on the same surface(s) of the same tooth within a two-year period • Ridge extensions for insertion of dentures • Major surgical procedures (e.g., mandibular osteotomy) • Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting • Root planing and/or subgingival curettage more than once in a 12-month period • Root canal treatment on the same tooth more than once in a two-year period • Replacement of a space maintainer, previously covered by the Plan • Procedures, appliances or restorations primarily for cosmetic purposes or nightguards • Orthodontic services • Missing teeth • Dental services started prior to the date the member enrolled in this Plan • Dental services not on our schedule allowance list <p>NOTE: The procedures and scheduled allowances listed in this brochure are intended as a summary of the most common procedures, not an exhaustive list. For questions regarding other specific procedures and scheduled allowances that fall under any of the preventive dental care or basic dental care bullets listed above, please call our Member Services department at 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699.</p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>						

Section 5 (i). Point-of-Service (POS) benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option there is no calendar year deductible.**
- **Under Standard Option** the calendar year deductible is \$350 per person (\$700 per family).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Facts about this Plan's POS option

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

What is covered

All services/treatments listed in this brochure as covered.

What is not covered

All services/treatments listed in this brochure as not covered including prescription drugs received from a non-Plan pharmacy except for out-of-area emergencies. Prescription drugs received from a non-Plan pharmacy due to an out-of-area emergency will be covered at the Plan benefit level. To receive full **non-emergency** Plan prescription drug benefits, you must use a Plan pharmacy or the Walgreens Pharmacy mail order program. Please see **Section 5(f), Prescription drug benefits** for details.

Emergency benefits

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

What you pay

When you **choose** to obtain services from a **non-Plan** doctor or hospital, KPS will:

- Determine what our allowable amount would have been for a Plan provider
- Reduce that amount by 25%
- Apply your appropriate cost sharing (i.e., deductible, coinsurance, and/or copayment) to the reduced amount
- Pay the non-Plan provider the balance

The non-Plan provider may balance bill you for the difference between what KPS pays and the original charges.

Examples are provided on the next page.

**Primary Care Office Visit Example
For High Option**

- You choose to go to a non-Plan provider for a primary care office visit and the charge is \$100.
- KPS determines that our allowable amount for a primary care office visit with a Plan provider is \$80.
- We reduce our allowable amount by 25%.
- The adjusted allowable amount is \$60.
- Under High Option you have a \$15 copayment for a primary care office visit.
- KPS applies your \$15 copayment to the \$60 adjusted allowable amount and pays the non-Plan provider \$45.
- The non-Plan provider may balance bill you for the \$55 difference between our \$45 payment and the original charge of \$100.

For Standard Option

- This example assumes you have used your first three (3) professional office visits and now your next primary care office visit is subject to the annual \$350 deductible, of which you have paid \$300, and 20% coinsurance.
- You choose to go to a non-Plan provider for a primary care office visit and the charge is \$100.
- KPS determines that our allowable amount for a primary care office visit with a Plan provider is \$80.
- We reduce our allowable amount by 25%.
- The adjusted allowable amount is \$60.
- KPS applies your remaining \$50 deductible payment to the \$60 adjusted allowable amount then applies your 20% coinsurance to the \$10 balance.
- KPS pays the non-Plan provider the remaining \$8.
- The non-Plan provider may bill you for the \$92 difference between our \$8 payment and the original charge of \$100.

**Non- Emergency Inpatient Hospital Care Example
For High Option**

- You choose to go to a non-Plan hospital for inpatient hospital care and the charge is \$10,000.
- KPS determines that our allowable amount for inpatient hospital care in a Plan hospital is \$8,000.
- We reduce our allowable amount by 25%.
- The adjusted allowable amount is \$6,000.
- Under the High Option inpatient hospital care benefit you pay 20% coinsurance.
- KPS applies your 20% coinsurance to the \$6,000 adjusted allowable amount and pays the non-Plan hospital \$4,800.
- The non-Plan hospital may bill you for the \$5,200 difference between our \$4,800 payment and the original charge of \$10,000.

For Standard Option

- This example assumes you have met \$300 of your annual \$350 deductible and spend three (3) days in the hospital.
- You choose to go to a non-Plan hospital for inpatient hospital care and the charge is \$10,000.
- KPS determines that our allowable amount for inpatient hospital care in a Plan hospital is \$8,000.
- We reduce our allowable amount by 25%.
- The adjusted allowable amount is \$6,000.
- Under the Standard Option inpatient hospital benefit, you must meet your annual deductible, pay a \$100 per day copayment for a maximum of five (5) days and pay 20% coinsurance.
- KPS applies your remaining \$50 deductible payment and a \$300 copayment to the \$6,000 adjusted allowable amount.
- KPS then applies your 20% coinsurance to the \$5,650 balance and pays the non-Plan hospital \$4,520.
- The non-Plan hospital may bill you for the \$5,480 difference between our \$4,520 payment and the original charge of \$10,000.

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 doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition. Certain services require pre-authorization and may be excluded unless the procedure discussed under *Services requiring our prior approval on page 12* is followed.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary as determined by the Plan;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices as determined by the Plan;
- 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; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699.

When you must file a claim – such as for services you receive outside of the Plan’s service area – submit it on the HCFA-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;
- 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: KPS Health Plans
Attn: Member Services
PO Box 339
Bremerton, WA 98337**

Prescription drugs

When you must file a claim – such for services you receive outside of the Plan’s service area – submit it on 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 of the pharmacy;
- Dates you received the services or supplies;
- Type of each service or supply;
- The charge for each service or supply; and
- Receipts, if you paid for your services.

**Submit your claims to: MedImpact
10680 Trenea Street, 5th floor
San Diego, CA 92131**

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 your claim if you do not respond.

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 pre-authorization:

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 six (6) months from the date of our decision; and(b) Send your request to us at: KPS Health Plans Attn: Resolution Department PO Box 339 Bremerton, Washington 98337(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 2, 1900 E Street, NW, Washington, DC 20415-3620.</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>

The Disputed Claims process (*Continued*)

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.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to 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 pre-certification or prior approval. This is the only deadline that may not be extended.

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

You may not 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.

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 pre-authorization/prior approval, then call us at 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699, and we will expedite our review; or
- (b) We denied your initial request for care or pre-authorization/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 2 at 202-606-3818 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 another group 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.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (800-633-4227) 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.

- **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 both 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 + Choice 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 the type of Medicare managed care plan you have.

- **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. Some things are not covered under Original Medicare, like prescription drugs.

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 probably will never have 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 360-478-6796 or toll free at 800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll free 800-420-5699.

We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:

- Copayments, coinsurance and deductibles applicable to inpatient hospital care, surgical and medical care and covered dental benefits.

Note: The High Option and Standard Option Prescription Drug Benefit copayment per prescription or per refill will still apply.

(Primary payer chart begins on 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) Are an active employee with the Federal government 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	✓	
2) Are an annuitant and... • You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
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)	✓*	
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)	✓*	
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) <i>Have Medicare solely based on end stage renal disease (ESRD) and...</i> • <i>It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)</i>		✓
• 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 your spouse are eligible for Medicare solely due to disability and you		
1) Are an active employee with the Federal government 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	✓	
2) Are an annuitant and... • You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
D. Are covered under the FEHB Spouse Equity provision as a former spouse	✓	

* Unless you have FEHB coverage through your spouse who is an active employee

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

- **Medicare +Choice**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare + Choice plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare + Choice plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare + Choice plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare + Choice plan, contact Medicare at 1-800-MEDICARE (800-633-4227) or at www.medicare.gov.

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

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

Suspended FEHB coverage to enroll in a Medicare + Choice plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare + Choice plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare + Choice 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 + Choice plan's service area.

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 the program.

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

Coverage under this Plan is excluded for expenses incurred or services rendered if your illness or injury is caused (or alleged by you to be caused) by another party, to the extent that benefits are available under the terms of any other insurance coverage or source of payment, including but not limited to: personal injury (“PIP”), no-fault medical, uninsured or underinsured motorist, workers’ compensation insurance or benefits and third party liability insurance, or similar contract of insurance.

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. This is called subrogation.

In order for our agreement to advance medical expenses involving a claim against a third party or its insurers, you agree to make a claim against the responsible party and its insurers for any and all amounts advanced by us. By providing benefits under this provision, we are fulfilling our obligations under this Plan. However, by so doing, we do not waive any rights to reimbursement or subrogation. If you are injured by a third party, benefits of this Plan will be advanced to you before compensation is recovered from the third party or its insurers, only under the following conditions:

- You and your representative(s) must fully cooperate with us in recovering payment of medical bills paid, and to be paid by us, from the parties who allegedly caused the injury or illness, including but not limited to their liability insurance carriers, any applicable PIP, uninsured or underinsured motorist policy, homeowners policy, workers compensation or any other reachable assets of the responsible party or parties;
- You notify us, in writing, of the details of the injury or illness, the names and addresses of the parties believed to be responsible and the names and addresses of the responsible party’s insurers, if known;
- Any claim or lawsuit filed by you against the third party or the third party’s insurer(s) must include a demand for repayment of benefits paid, or to be paid, by us on your behalf; or
- You must agree to assign to us your right to recover compensation for medical costs paid (subrogation), or to be paid, by us as a result of injuries caused by the third party responsible for the injury;
- You must agree to reimburse us for the cost of medical care provided by us as a result of the injury, from the settlement, judgment, insurance proceeds or other recovery obtained by you from any third party or its insurers.

You or your representative(s) must obtain a written agreement from us prior to settling any claim if you want us to share, on an equitable basis, any reasonable attorney fees incurred by you in pursuit of any subrogation or reimbursement claim. In the absence of a prior written agreement, we, at our sole discretion, will determine whether or not to reduce our reimbursement amount in order to share, on an equitable basis, any reasonable attorney fees incurred by you. However, such a reduction will only be considered if we have benefited from the services of your attorney. In no event will our reimbursement be

reduced by more than twenty percent (20%) to offset attorney fees incurred by you, and we will not pay for other costs incurred by you.

You and your representative(s) must deal in good faith with us by adhering to all of the conditions set forth in this Section. In turn, we agree to cooperate with you and your representative(s) in your effort to recover reimbursement, and will advance payments on your behalf for injuries or medical conditions caused, or alleged by you to be caused, by any third party. You and your representative(s) must cooperate fully with us in protecting, preserving, and recovering the amounts we have paid or will pay on your behalf under this Plan. Failure to cooperate may result in the denial of coverage for injuries or conditions caused, or asserted by you to be caused by any third party, to the extent that coverage or payment for such injuries or illnesses is, or would have been, available under the terms of any other insurance coverage or source of payment.

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 page 15.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 15.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care you receive in an institution, such as room and board or other supportive care, or in your home that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist you in activities of daily living. Activities of daily living include but are not limited to: help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets, supervision of medications that you would normally self-administer. Custodial care that lasts 90 days or more is sometimes known as long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 15.
Experimental or investigational services	<p>A drug, device or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished.</p> <p>An FDA-approved drug, device or biological product or medical treatment or procedure is experimental or investigational if:</p> <ol style="list-style-type: none">1) Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety; or2) Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. <p>Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.</p> <p>FDA-approved drugs, devices, or biological products used for their intended purposes and labeled indication and those that have received FDA approval subject to postmarketing approval clinical trials, and devices classified by the FDA as “Category B Non-experimental/investigational Devices” are not considered experimental or investigational.</p>

Medical necessity

A service or supply which meets all of the following criteria:

- 1) It is consistent with the symptom or diagnosis and treatment of the condition;
- 2) It is the most appropriate supply or level of service that is essential to the members needs;
- 3) When applied to an inpatient, it cannot be safely provided to the member as an outpatient;
- 4) It is appropriate with regard to good medical practice;
- 5) It is not primarily for the convenience of the member or provider; and
- 6) It is the most cost-effective of the alternative levels of service or supplies that are adequate and available.

The fact that a service or supply may have been furnished, prescribed, recommended or approved by a doctor or other provider does not of itself make it medically necessary. A service or supply may be medically necessary in part only.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

- 1) **Plan providers:** Our allowance is the amount agreed upon between the Plan provider and us. Plan providers agree not to bill you for any charges above our allowance.
- 2) **Non-Plan providers:** Our allowance is reduced by 25% when you see a non-Plan provider, except in an emergency. You are responsible for all charges above our allowance. See Section 3 for other exceptions and Section 5(i) for Point-of-Service benefit details.

Us/We

“Us” and “we” refer to KPS Health Plans.

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 that 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. 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 health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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 Federal Employees Health Benefits (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 option of 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 on 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 2004 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 2003 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.

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

- **Spouse equity coverage**

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 supply health coverage for you. But, you may be eligible for your own FEHB coverage under 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 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 (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 have information about Federal and State agencies you can contact for more information.

Two new Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you know about two new Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20 to more than 40 percent on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** covers long term care costs not covered under the FEHB.

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. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%!!*

There are two types of FSAs offered by the FSAFEDS Program:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. **Note:** The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is \$3,000 annually. The minimum amount is \$250 annually.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is \$5,000 annually. The minimum amount is \$250 annually. **Note:** The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!

- Enroll online anytime during Open Season (November 10 through December 8, 2003) at www.fsafeds.com.
- Call the toll-free number 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time and a FSAFEDS Benefit Counselor will help you enroll.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and will be responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you're not enrolled in FEHB – you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The

only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the “use-it-or-lose-it” rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFEDS during this Open Season.

The **FSAFEDS Calculator** at www.fsafeds.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 75 and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

Under the High Option of this Plan, typical out-of-pocket expenses include:

- \$15 office visit copayment (primary care)
- Prescription drug copayments:
 - Tier 1-\$5
 - Tier 2-\$20
 - Tier 3-\$100 or 50% whichever is less
- \$25 per member (\$50 family) annual deductible for Basic Dental care

Under the Standard Option of this Plan, typical out-of-pocket expenses include:

- \$350 per member (\$700 family) annual deductible (applies to most services)
- \$15 copayment for first three (3) office visits and 20% coinsurance
- Prescription drug copayments:
 - Tier 1-\$10
 - Tier 2-\$30
 - Tier 3-50% with minimum \$40 prescription price

In addition, there are certain services or expenses that are NOT covered under this Plan that may be reimbursed under a HCFSA, these include:

- Out-of-network charges above Plan allowance
- Dental charges above Plan allowance
- Prescription eyeglasses or contacts

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. If you do not see your service or expense listed in Publication 502, please call a FSAFEDS Benefit Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will also be lower. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into a FSA:	\$ 2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$ 2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon in which retirement system you are enrolled (CSRS or FERS), as well as your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

Health care expenses

You *cannot* claim expenses on your Federal income tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

The HCFSA is tax-free from the first dollar. In addition, you may be reimbursed from the HCFSA at any time during year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example listed in the above chart, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exception is not available on your Federal income tax return.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

Probably not. While there is an administrative fee of \$4.00 per month for an HCFSA and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFEDS.com Web site or call 1-877-FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if don't spend your entire account balance by the end of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

- **Contact us**

To find out more or to enroll, please visit the **FSAFEDS Web site** at www.fsafeds.com, or contact SHPS by email or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

- E-mail: fsafeds@shps.net
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450 (for hearing impaired individuals that would like to utilize a text messaging service)

The Federal Long Term Care Insurance Program

It's important protection

Here's why you should consider enrolling in the Federal Long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive when you need assistance performing activities of daily living – such as bathing or dressing yourself. This need 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 control over the type of care you receive and where you receive it. It can also help you remain independent, so you won't have to worry about being a burden to your loved ones.
- **It's to your advantage to apply sooner rather than later.** Long term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical 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 change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, 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. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

To find out more and to request an application

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Summary of benefits for KPS Health Plans – 2004

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover. For more details, 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. An asterisk (*) next to an item listed below means it is subject to the \$350 per person (\$700 per family) calendar year deductible.

Benefits	You Pay – High Option	You Pay – Standard Option	Page
Medical services provided by physicians:			
• Diagnostic & treatment services provided in the office	Primary care office visit copay: \$15 Specialty care office visit copay: \$25	\$15 copayment for first three (3) professional office visits For all subsequent visits 20% coinsurance applies*	19
• Lab, X-ray and other diagnostic tests	20%	20%*	20
Services provided by a hospital:			
• Inpatient.....	20%	20%*	35
• Outpatient.....	20%	20%*	36
Emergency benefits:			
• In-area.....	Emergency Room: \$75 copay Urgent Care: \$15 copay	Emergency Room: 20%* Urgent Care: 20%	39
• Out-of-area	Emergency Room: \$75 copay Urgent Care: \$15 copay	Emergency Room: 20%* Urgent Care: 20%	39
Mental Health & Substance Abuse treatment	Regular cost sharing	Regular cost sharing	41
Prescription drugs	Tier 1: \$5 Tier 2: \$20 Tier 3: \$100 or 50%, whichever is less	Tier 1: \$10 Tier 2: \$30 Tier 3: 50% with \$40 minimum prescription price	45
Prescription drugs with Medicare A & B Primary	Tier 1: \$3 Tier 2: \$12 Tier 3: \$100 or 50%, whichever is less	Tier 1: \$10 Tier 2: \$30 Tier 3: 50% with \$40 minimum prescription price	45
Dental Care	Preventive Care: All charges in excess of the scheduled allowance.	Preventive Care: All charges in excess of the scheduled allowance.	48
	Basic Dental Care: \$25 per person or \$50 per family deductible, then all charges in excess of the Scheduled Allowance. All charges in excess of the \$1,000 annual maximum per member for all services combined.	No benefit	49
Vision Care			
• Annual eye exam-adult.....	Office visit copay: \$15	Office visit: 20%*	26
• Eye exam for children through age 17.....	Office visit copay: \$15	Office visit: 20%	26
Special features	See Section 5(g)	See Section 5(g)	47
Point of Service benefits	See Section 5(i)	See Section 5(i)	53
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$5,000/person or \$5,000/family per year. Some costs do not count toward this protection.	Nothing after \$5,000/person or \$5,000/family per year. Some costs do not count toward this protection.	17

2004 Rate Information for KPS Health Plans

Non-Postal rates apply to most non-Postal enrollees. 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	Code	<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Clallam/Clark/Cowlitz/Grays Harbor/Island/Jefferson/King/Kitsap/Lewis/Mason/Pacific/Pierce/San Juan/Skagit/Skamania/Snohomish/Thurston/Wahkiakum/Whatcom counties

High Option Self Only	VT1	\$121.40	\$57.47	\$263.03	\$124.52	\$143.32	\$35.55
High Option Self & Family	VT2	\$277.09	\$113.75	\$600.36	\$246.46	\$327.12	\$63.72
Standard Option Self Only	L11	107.99	\$36.00	\$233.99	\$77.99	\$127.79	\$16.20
Standard Option Self & Family	L12	\$235.97	\$78.66	\$511.28	\$170.42	\$279.23	\$35.40