

KPS Health Plans

www.kpshealthplans.com

KPS

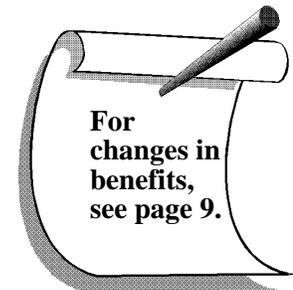
health plans

2007

**A Prepaid Comprehensive Medical Plan (high and standard option)
with a Point-of-Service product, and a high deductible health plan**

Serving: All of Washington State

**For changes in benefits see page 9. Enrollment in this plan is limited.
You must live or work in our Geographic service area to enroll. See page
8 for requirements.**



Enrollment codes for this Plan:

- VT1 High Option – Self Only**
- VT2 High Option – Self and Family**
- L11 Standard Option – Self Only**
- L12 Standard Option – Self and Family**
- L14 High Deductible Health Plan (HDHP) – Self Only**
- L15 High Deductible Health Plan (HDHP) – Self and Family**

Authorized for distribution by the:



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

**Important Notice from KPS Health Plans About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the KPS Health Plans' prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordination Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

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Introduction

This brochure describes the benefits of 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 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, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 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 instance, “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 U.S. Office of Personnel Management, Insurance Services Programs, 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 Program premium.

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

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

- Do not give out your plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

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

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

If the provider does not resolve the matter, call us at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Visit these Web sites for more information about patient safety.

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

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

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

Section 1 Facts about this 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. We give you a choice of enrollment in a High Option, a Standard Option, or a High Deductible Health Plan (HDHP).

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

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

General features of our High and Standard Options

Both High and Standard options provide comprehensive medical, surgical and hospitalization benefits in addition to coverage for alternative care providers, dental benefits, mental health care, and an open formulary prescription benefit.

We have Point-of-Service (POS) benefits

Our Plan offers POS benefits. This means you can receive covered services from a non-Plan provider 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 High and Standard Option Section 5(i), page 64, 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 (on basic and major 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 Preferred Provider Organization. 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.

In Washington State, we arrange with healthcare providers (9,162 primary care physicians; 17,335 specialists; 3,630 behavioral health providers; 4,529 alternative care providers) and hospitals (89) to provide medical care for both the prevention of disease and the treatment of serious illness. For medical care received outside our service area, we contract with the MultiPlan National Provider Network and Providence Preferred Provider Organization.

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans.

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. In addition, your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

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

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

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$5,000 for Self Only enrollment, or \$10,000 family coverage.

Health education resources and account management tools

KPS Health Plans has chosen Wells Fargo Bank to be our HSA/HRA administrator. As a KPS HDHP enrollee, you will have the following health education resources and account management tools provided or made available to you:

- At the Wells Fargo website (www.wfhbs.com) you can easily view account balances and information, change investment options, download forms and link to a list of covered expenses.
- Through the Wells Fargo toll-free HSA customer service line 1-866-890-8309 or HRA customer service line 1-800-473-0926 you can access automated information 24 hours a day, or speak with a helpful customer service representative from 5:00 am to 5:00 pm Monday through Friday, Pacific Time.
- A Wells Fargo new enrollee welcome kit with valuable instructions and account information will be mailed to you shortly after enrolling.
- Convenient access to funds is made available through Wells Fargo debit cards. HSA members will receive the Health Savings Account Visa® debit card and HRA members will receive the Benny™ card.
- Other important tools and information are available by visiting the KPS website at www.kpshealthplans.com.

For more details please refer to **Section 5(i) Health education resources and account management tools** on page 108.

Your rights

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

- Years in existence
- Profit status

If you want more information about us, call 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699, 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 is all of Washington State.

As described in "How we pay providers" on page 6, 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. For details regarding out-of-network services, please see Section 5(i), page 64, *Point-of-Service (POS) benefits* for High and Standard Option and Section 5, page 68, *High Deductible Health Plan Benefits Overview* for HDHP.

If you or a covered family member move outside of our service area, you can enroll in another plan. Please contact us first, however, at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699 to confirm there are no Plan providers available where you or a covered family member may be moving. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2 How we change for 2007

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

Changes to High Option only

- **For High Option Enrollees, codes VT1 and VT2**, your share of the non-Postal premium will **decrease by 3.9%** for Self Only enrollment and by **4.1%** for Self and Family enrollment.
- We have removed provisional splinting and precision attachment as covered dental procedures from Section 5(h) *Dental benefits*.

Changes to Standard Option only

- **For Standard Option enrollees, codes L11 and L12**, your share of the non-Postal premium will **not change** for Self Only enrollment and for Self and Family enrollment.

Changes to HDHP only

- **For HDHP, codes L14 and L15**, your share of the non-Postal premium will **not change** for Self Only enrollment and for Self and Family enrollment.
- We have removed space maintainer-fixed-unilateral (D1510) as a covered preventive dental care procedure from Section 5 *Preventive care*.

Changes to High and Standard Option and HDHP

- We have added varicella (chickenpox) and tetanus, diphtheria and pertussis (Tdap) to the list of routine immunizations for *Preventive care, adult*. See pages 22 and 78.
- We have added retinal screening exam for newborns performed by an ophthalmologist to *Preventive care, children*. See pages 23 and 79.
- We have listed coverage for diabetic education, equipment and supplies as a group. See pages 28 and 87.
- We have enhanced our benefit for *Organ/tissue transplants*. See pages 37-39 and 93-95.
- We have removed cephalometric film (D0340) from the list of covered dental procedures from Section 5(h) *Dental benefits* for High and Standard Option and Section 5 *Preventive care* for HDHP.

Clarifications

- We have revised *Physical and occupational therapies* to show massage therapy may be prescribed by a qualified provider. See pages 26 and 85.
- We have added reflexology and Rolfing under what's *Not covered* for *Physical and occupational therapies* and *Alternative treatments*. See pages 27, 31, 85 and 89.
- We have changed the Wells Fargo customer service toll-free number for HSA information to 1-866-890-8309 and the HRA toll-free number to 1-800-473-0926.

Section 3 How you get care

Identification cards	<p>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 electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>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 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699 or write to us at P.O. Box 339, Bremerton, Washington 98337. You may also request replacement cards through our Web site at www.kpshealthplans.com.</p>
Where you get covered care	<p>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. If you use our Point-of-Service program, you can also get care from non-Plan providers but it will cost you more.</p> <p>You get dental care from any licensed dentist within the United States.</p>
<ul style="list-style-type: none">• Plan providers	<p>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.</p> <p>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 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699. 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.</p>
<ul style="list-style-type: none">• Plan facilities	<p>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.</p>
What you must do to get covered care	<p>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.</p>
<ul style="list-style-type: none">• Primary care	<p>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.</p> <ul style="list-style-type: none">• Specialists are listed in our provider directory. No referral is required.• Here are some other things you should know about specialty care:• If you are seeing a specialist and your specialist leaves the Plan, you will be allowed 60 days from the date we notify you that the specialist has left the Plan to either (i) complete your course of treatment, or (ii) appropriately transfer your care to another Plan provider. If, after 60 days, you have not completed your course of treatment or transferred your care to another Plan provider, your benefits will be paid at the lower Point-of-Service (POS) rate described in Section 5(i), page 64, for High and Standard Option and page 68 for HDHP.• If you have a chronic and disabling condition and lose access to your specialist because we:

- **Specialty care**
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program 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 and extremity manipulations and acupuncture needle treatments are each limited to 18 treatments per calendar year under High and Standard Option. Under the HDHP spinal and extremity manipulations and acupuncture needle treatments are each limited to 12 treatments per calendar year. Massage therapy is part of the physical, rehabilitation and speech therapy benefit (see Section 5(a), pages 26, 27 and 85). The non-Plan provider reduction in benefits applies (see High and Standard Option Section 5(i), *Point-of-Service (POS) benefits*, page 64, and *HDHP Section 5, High Deductible Health Plan Benefits Overview– Out-of-network services*, page 68).

- **Hospital care**

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

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 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

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

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

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

How to get approval for...

• **Your hospital stay**

Pre-Admission Certification: Pre-admission certification authorizes inpatient hospital benefits and is valid for 30 days. Approval for each admission or re-admission is required. We will provide coverage only for the number of hospital days that are medically necessary and appropriate for your condition. If your hospital stay is extended due to complications, your 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.

- 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.

• **How to preauthorize a service or treatment**

- To obtain preauthorization for a service or treatment, call 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699. Member Services will confirm that the service or treatment requires preauthorization. If it does, you will be transferred to the Medical Services department where all the information needed to determine authorization will be taken. A staff nurse will review the request and send you and your provider notification in writing of the decision. The same process applies when the service or treatment is received from a non-Plan provider; or if an extension to the prior authorization is required.

• **Maternity care**

- Maternity care does not require preauthorization.

• **What happens when you do not follow the preauthorization rules**

- If a service or treatment that requires preauthorization is performed without obtaining the authorization, a retro-review may be done to determine if it is a covered benefit and if it was medically necessary. KPS will not pay for services or treatments that are not covered or that are not medically necessary.
- If the hospitalization and treatment is not preauthorized, our allowance for the admitting physician's fees will be reduced by 20% and benefits for the hospital stay will be reduced by \$500.

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 preauthorization. You or your physician must obtain preauthorization for the following:

- Blepharoplasty
- Bone growth stimulators
- Breast surgeries
- CPM machines
- Electric scooters
- Enteral therapy

- Genetic testing
- Growth hormone treatment (pre-authorized by MedImpact)
- Home health & hospice
- Home IV infusion
- Hyperbaric oxygen pressurization
- Inpatient services
- Insulin pump
- LAUP
- Mental health & substance abuse treatments
- Organ transplants
- Penile prosthesis
- PET scans
- Pneumatic compression device
- Pulse dye laser
- Removal of scars
- Respiratory syncytial virus agent
- RSV immunization
- Sclerotherapy
- Skilled nursing facility care
- Sleep disorders surgery
- SPECT scans
- Synchromed pump
- UPPP
- Urinary incontinence treatment w/biofeedback
- Ventilators

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 & lesions
- Sterilization procedures
- Tendon, bone, and joint surgery of the hand and foot

Section 4 Your costs for covered services

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

Copayments

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

Example:

Under High Option, you pay a copayment of \$20 per office visit.

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.

Under the High Deductible Health Plan (HDHP), you pay a \$10 copayment for Tier 1 drugs and a \$30 copayment for Tier 2 drugs.

Deductible

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

- **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 and major 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 Standard Option deductible** is waived for the first three (3) professional office visits (see **Copayments** above), preventive care and accidental injuries.
- **The High Deductible Health Plan (HDHP)** calendar year deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment. The Self and Family deductible can be satisfied by one or more family members.

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.

And, 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. Exceptions are infertility services; sleep disorders and treatment of morbid obesity that have a 50% coinsurance.

See *Your catastrophic protection out-of-pocket maximum* on page 16 for more information regarding coinsurance.

Difference between our Plan allowance and the bill

Our “Plan allowance” is the amount we use to calculate our payment for covered services. As a general rule, you may receive care from any licensed or certified healthcare provider or hospital. *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.

Under High and Standard Option, if you choose a non-Plan provider, your out-of-pocket costs are significantly higher because they have no agreement with KPS to limit what they will bill you. When you use a non-Plan provider, the KPS allowed amount for covered services is reduced by 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 allowed by KPS. This is called “balance billing”.

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 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 less 25%?	No: 100	Yes: 75
We pay	80% of our allowance: 80	80% of reduced allowance: 60
You owe coinsurance	20% of our allowance: 20	20% of 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 deductible, copayment or coinsurance. 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*, page 43 and 99).
- **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 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699 **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 (if it is a medically necessary/covered benefit) after you have met any applicable deductible, copayment or coinsurance.

Under the HDHP, if you choose a non-Plan provider, we pay 60% of our allowed amount for covered services. It is your responsibility to pay the difference between the amount billed by the non-Plan provider and the amount allowed by KPS. This is called “balance billing”.

Your catastrophic protection out-of-pocket maximum

For both High Option and Standard Option, after your copayments, coinsurance and the Standard Option deductible 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.

For the HDHP, after your deductible, coinsurance and copayments total \$5,000 per person or \$10,000 per family enrollment in any calendar year, you do not have to pay any more for covered services.

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

<ul style="list-style-type: none"> • Copayments for professional services of physicians: <ul style="list-style-type: none"> o In a physician’s office o In an urgent care center o Office medical consultations o Second surgical opinion 	<ul style="list-style-type: none"> • 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
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For the HDHP, you must continue to pay all applicable charges for expenses in excess of the Plan’s allowable amount or benefit maximum (e.g., preventive dental care fee schedule amounts, \$2,500 annual durable medical equipment maximum).

Carryover

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

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

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.

High and Standard Option Benefits

See page 9 for how our benefits changed this year. Page 129 and page 130 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5 High and Standard Option Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High and Standard Option benefits, contact us at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699 or at our Web site at www.kpshealthplans.com.

Each option offers unique features.

<ul style="list-style-type: none"> • High Option 	<ul style="list-style-type: none"> • No calendar year deductible • Preventive, basic and major dental benefits • Alternative care provider coverage • \$5 copayment for generic drugs • Reduced prescription drug copayments for enrollees with Medicare Parts A & B
<ul style="list-style-type: none"> • Standard Option 	<ul style="list-style-type: none"> • 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) are covered with only a \$15 copayment and no deductible • Preventive dental benefit • Alternative care provider coverage • \$10 copayment for generic drug

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and 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 64.**

Benefit Description	You pay After the calendar year deductible...	
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>		
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • Office medical consultations • Second surgical opinion <p>Note: Under High Option, you pay a copayment for office visits billed with codes corresponding to these services.</p> <p>Example for Standard Option:</p> <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. 	\$20 copayment per office visit	\$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
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 • At home 	20%	20%

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
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	High Option	Standard Option
Routine screenings, such as: <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening – ultrasonography, one between the age of 65 and 75, for men with smoking history • Complete Blood Count, one annually • Total Blood Cholesterol, once every 3 years • A fasting lipoprotein profile (total cholesterol, LDL, HDL and tryglycerides) once every 5 years for adults 20 or over 	\$20 copayment per office visit	Nothing up to \$500 combined annual maximum for preventive care allowable charges. Once \$500 maximum is reached, you pay all additional charges. (No deductible)
<ul style="list-style-type: none"> • Colorectal Cancer Screening, including • 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 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 <p>Note: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and treatment services, page 20.</i></p>	\$20 copayment per office visit	Nothing up to \$500 combined annual maximum for preventive care allowable charges. Once \$500 maximum is reached, you pay all additional charges. (No deductible)
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period 	20%	Nothing up to \$500 combined annual maximum for preventive care allowable charges.

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> From age 40 through 64, one every calendar year At age 65 and older, one every two consecutive calendar years 	20%	Nothing up to \$500 combined annual maximum for preventive care allowable charges. Once \$500 maximum is reached, you pay all additional charges. (No deductible)
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): <ul style="list-style-type: none"> Varicella (Chickenpox) – for persons age 19 to 49 Tetanus, Diphtheria and Pertussis (Tdap) – for persons age 19 to 64 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 vaccine, age 65 & older 	Nothing	Nothing Not subject to \$500 combined annual maximum for preventive care
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>	<i>All charges.</i>
Preventive care, children	High Option	Standard Option
<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 (up to age 22) 	Nothing	Nothing Not subject to \$500 combined annual maximum for preventive care
<ul style="list-style-type: none"> Examinations, such as: <ul style="list-style-type: none"> Retinal screening exam for newborns performed by an ophthalmologist Eye exams through age 17 to determine the need for vision correction Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) 	Nothing	20% (No deductible)
Maternity care	High Option	Standard Option
Complete maternity (obstetrical) care by a physician, certified nurse midwife, or licensed midwife for: <ul style="list-style-type: none"> Prenatal care Delivery (including home births) Postnatal care Note: Here are some things to keep in mind:	20%	20%

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Maternity care (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see Section 3 for other information. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a Cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. See Section 5(b), page 34, for circumcision benefits. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits Section 5(c), page 40, and Surgery benefits Section 5(b), page 34. • Dependent child – pregnancy, delivery and care of newborn during hospital stay is covered. 	20%	20%
<p>Not covered:</p> <ul style="list-style-type: none"> • <i>Routine sonograms to determine fetal age, size or sex</i> • Care of a dependent child’s newborn once the mother is discharged from the hospital unless the newborn is determined to be your dependent by your personnel office 	<i>All charges.</i>	<i>All charges.</i>
Family planning	High Option	Standard Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b), page 34) • 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 counseling</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...	
Infertility services	High Option	Standard Option
Diagnosis & treatment of infertility such as: <ul style="list-style-type: none"> • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) 	20%	20%
Not covered: <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: • in vitro fertilization • embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) • zygote transfer • intrauterine insemination (IUI) • Services and supplies related to excluded ART procedures • Cost of donor sperm • <i>Cost of donor egg</i> • <i>Fertility drugs</i> 	<i>All charges.</i>	<i>All charges.</i>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	20%	20%
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	High Option	Standard Option
<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>, page 37.</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; preauthorization required • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	20%	20%

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Treatment therapies (cont.)	High Option	Standard Option
<p>We only cover GHT when we preauthorize the treatment. Call MedImpact at 1-800-788-2949 for preauthorization. They will ask you to submit information that establishes that the GHT is medically necessary. Ask them 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 the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	20%	20%
Neurodevelopmental therapies	High Option	Standard Option
<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	High Option	Standard Option
<p>Up to 60 visits per year combined for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists • occupational therapists • licensed massage therapists (when prescribed by a qualified provider) <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%	<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>
<p>Cardiac rehabilitation is provided for up to \$1,000 following:</p> <ul style="list-style-type: none"> • Heart transplant; 	20%	20%

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Physical and occupational therapies (cont.)		
<ul style="list-style-type: none"> • Bypass surgery; • Myocardial infarction; • Heart valve repair/replacement; or • Combined heart-lung transplant 	20%	20%
<i>Not covered:</i> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs • Reflexology • Rolfing 	<i>All charges.</i>	<i>All charges.</i>
Speech therapy	High Option	Standard Option
Licensed speech therapist Note: Speech therapy is combined with 60 visits per year for the services of physical therapy and/or occupational therapy (see above)	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)	High Option	Standard Option
<ul style="list-style-type: none"> • Hearing tests for children through age 17 (For routine screening hearing exams see <i>Preventive care, children</i>, page 23) 	20%	20%
<i>Not covered:</i> <ul style="list-style-type: none"> • Hearing tests for those over age 17 • Hearing aids, testing and examinations for them 	<i>All charges.</i>	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	High Option	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 • Eye exams to determine the need for vision correction for children through age 17 (For routine screening eye exams see <i>Preventive care, children</i>, page 23) 	\$20 copayment per exam	20%
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>

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

Benefit Description	You pay After the calendar year deductible...	
Vision services (testing, treatment, and supplies) (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Eyeglasses or contacts except as related to accidental ocular injury or intraocular surgery</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	High Option	Standard Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See <i>Orthopedic and prosthetic devices</i>, page 29, 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>
Diabetic education, equipment and supplies	High Option	Standard Option
<p>Health Education and Training</p> <ul style="list-style-type: none"> • Nutritional guidance <p>Medical Equipment</p> <ul style="list-style-type: none"> • Dialysis equipment • Insulin pumps (requires prior authorization) • Insulin infusion devices • Glucometers • Medically necessary orthopedic shoes & inserts <p>Supplies other than those covered under <i>Prescription drug benefits</i> such as:</p> <ul style="list-style-type: none"> • Orthopedic and corrective shoes • Arch supports • Foot orthotics • Heel pads and heel cups • Elastic stockings, support hose • Prosthetic replacements 	20%	20%

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Orthopedic and prosthetic devices</p> <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 <p>Note: This benefit (except for externally worn breast prostheses and surgical bras) combined with the <i>Durable medical equipment (DME)</i> benefit 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), page 40, for payment information. See Section 5(b), page 34, 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(except for externally worn breast prostheses and surgical bras)</i> 	<i>All charges.</i>	<i>All charges.</i>
<p>Durable medical equipment (DME)</p> <p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> Oxygen Hospital beds Wheelchairs Crutches Walker Motorized wheelchairs 	20%	20%

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<p>Note: This list is not complete. For more details please contact Member Services at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699.</p> <p>Note: This benefit (except for oxygen) 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%
<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>DME purchased from non-Plan providers (e.g., through the Internet)</i> 	<i>All charges.</i>	<i>All charges.</i>
Home health services	High Option	Standard Option
<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. • Note: These services require precertification. Please refer to the precertification information shown in Section 3. • Note: Therapy (physical, occupational, speech) applies towards your therapy maximum of 60 visits per calendar year. 	\$20 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>

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Chiropractic		
<ul style="list-style-type: none"> Up to 18 treatments per calendar year for manipulation of the spine and extremities 	\$20 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> <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		
<ul style="list-style-type: none"> Acupuncture – up to 18 treatments per calendar year when treatment is received by a licensed Plan provider Naturopathic services 	\$20 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"> <i>Herbs prescribed by an acupuncturist or naturopath</i> <i>Hypnotherapy</i> <i>Biofeedback</i> <i>Reflexology</i> <i>Rolfing</i> 	<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 <i>Prescription drugbenefits</i> to a lifetime maximum of \$350 per member. 	\$20 copayment per office visit	20% (No deductible)
Outpatient nutritional guidance counseling services by a registered dietitian for the following conditions: <ul style="list-style-type: none"> Cancer Endocrine conditions 	20%	20% (No deductible)

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Educational classes and programs (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Swallowing conditions after stroke • Hyperlipidemia • Colitis • Coronary artery disease • Dysphagia • Gastritis • Inactive colon • Anorexia • Bulimia • Short bowel syndrome (post surgery) • Food allergies or intolerances • Obesity <p>Up to \$400 maximum per member per year.</p>	20%	20% (No deductible)
<i>Not covered: Over-the-counter drugs</i>	<i>All charges.</i>	<i>All charges.</i>
Sleep disorders	High Option	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 purposes 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 • The condition giving rise to the sleep disorder (such as narcolepsy or sleep apnea) must be diagnosed by your provider. Preauthorization of sleep studies is not required; however, you must be referred to the sleep studies program by your provider. • Surgical treatment – of the above listed sleep disorders will be limited to a lifetime maximum of \$3,000. 	50%	50%

Sleep disorders - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Sleep disorders (cont.)	High Option	Standard Option
Coverage for the medically necessary surgical treatment of diagnosed sleep disorders is covered under this benefit. Preauthorization of surgical procedures for the treatment of sleep disorders is required. Surgical treatment includes all professional and facility fees related to the surgical treatment including pre- and post-operative care and complications.	50%	50%
<i>Not covered: Any service not listed above for the purpose of studying, monitoring and/or treating sleep disorders.</i>	<i>All charges.</i>	<i>All charges.</i>
Temporomandibular joint (TMJ) disorders	High Option	Standard Option
Treatment of TMJ, including surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy	20%	20%
<i>Not covered:</i> <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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **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 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 (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- **For non-Plan provider benefit see Section 5(i), *Point-of-Service (POS) benefits*, page 64.**

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Surgical procedures	High Option	Standard Option
A comprehensive range of services, such as: <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Insertion of internal prosthetic devices. See Section 5(a), page 29, <i>Orthopedic and prosthetic devices</i> for device coverage information. • Circumcision from birth to one month old or as medically necessary 	20%	20%

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Surgical procedures (cont.)		
<ul style="list-style-type: none"> Surgical treatment (bariatric surgery) and all services associated with the 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 <p>Note: The surgical candidate must be at least 18 years or older, have a Body Mass Index (BMI) of greater than 40 or 35 with at least two of the following comorbidities: sleep apnea, diabetes, hypertension, coronary artery disease and hyperlipidemia. All inpatient and outpatient surgical treatment for morbid obesity must be preauthorized. See <i>Services requiring prior approval</i> in Section 3.</p>	50%	50%
<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 Hospital benefits for a pacemaker and Surgery benefits 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; see Section 5(a), page 28, 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 <p>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.</p> <ul style="list-style-type: none"> All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> surgery to produce a symmetrical appearance of breasts; 	20%	20%

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Reconstructive surgery (cont.)		
<ul style="list-style-type: none"> - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Section 5(a), page 29, <i>Orthopedic and prosthetic devices</i>) <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		
<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>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas 	20%	20%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas <p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses (the medical necessity limitation is considered satisfied if the patient meets the staging description):</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma - Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	20%	20%
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Mucopolidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) 	20%	20%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Amyloidosis - Ependyblastoma - Ewing’s sarcoma - Medulloblastoma - Pineoblastoma 	20%	20%
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic lymphocytic leukemia - Chronic myelogenous leukemia • Autologous transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia 	20%	20%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • National Transplant Program (NTP) <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>Transplants not listed as a covered benefit</i> 	<i>All charges.</i>	<i>All charges.</i>
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	20%	20%

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **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 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 the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) and (b), pages 20 and 34.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.
- **For non-Plan provider benefit see Section 5(i), *Point-of-Service (POS) benefits*, page 64.**

Benefit Description	You pay	
Note: The calendar year deductible applies only when we say below: “(calendar year deductible applies)”.		
Inpatient hospital	High Option	Standard Option
Room and board, such as: <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; 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, birthing centers 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 (except medications) • 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

Benefit Description	You pay	
Inpatient hospital (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Take home medications 	<i>All charges.</i>	<i>All charges.</i>
Outpatient hospital or ambulatory surgical center	High Option	Standard Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • 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"> • Blood and blood derivatives not replaced by the member • Take home medications 	<i>All charges.</i>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits	High Option	Standard Option
<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 preauthorization by our medical director.</p>	20%	20%
<p><i>Not covered: Custodial care</i></p>	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
	High Option	Standard Option
<p>Hospice care</p> <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 • Inpatient hospice benefits are provided for up to five (5) consecutive days in a hospital or a freestanding hospice inpatient facility. • Each inpatient stay must be separated by at least 21 days. • These covered inpatient hospice benefits are available only when inpatient services are necessary to: • 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: Independent nursing, homemaker services</i></p>	<i>All charges.</i>	<i>All charges.</i>
<p>Ambulance</p> <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: The use of any type of ambulance transportation for personal convenience.</i></p>	<i>All charges.</i>	<i>All charges.</i>

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and 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.

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.

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.

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

Emergencies outside our service area:

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

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

Follow-up care received from non-Plan providers and/or at a non-Plan facility when the care could be received from a Plan provider and/or at a Plan facility, will be covered at the Point-of-Service (POS) benefit level. See Section 5(i), page 64.

Benefit Description	You pay After the calendar year deductible...	
Emergency within our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at a doctor's office Emergency care at an urgent care center 	\$20 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 doctor's 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%
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>	<i>All charges.</i>
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at a doctor's office Emergency care at an urgent care center 	\$20 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 doctor's 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>

Benefit Description	You pay After the calendar year deductible...	
Ambulance	High Option	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), page 42, for non-emergency service.</p>	20%	20%
<i>Not covered: The use of any type of ambulance transportation for personal convenience.</i>	<i>All charges.</i>	<i>All charges.</i>

Section 5(e) Mental health and substance abuse benefits

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and 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 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 PREAUTHORIZATION OF 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 64.**

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Mental health and substance abuse benefits	High Option	Standard Option
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. 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.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<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 	\$20 copayment per office visit	\$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
Diagnostic tests <ul style="list-style-type: none"> • Services provided by a hospital or other facility 	20%	20%

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Mental health and substance abuse benefits (cont.)		
<ul style="list-style-type: none"> Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 		
<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>
Preauthorization	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:</p> <p>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 1-800-223-6114 before services are provided. If pre-authorization is <u>not</u> obtained, payment for the services will be denied.</p> <p>Note: Pre-authorization is not required for treatment rendered by a state hospital when the member has been involuntarily committed.</p> <p>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.</p>	
Limitation	We may limit your benefits if you do not obtain a treatment plan.	

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 50.
- 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.
- 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.

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

- **Who can write your prescription.** A physician, podiatrist, advanced registered nurse practitioner (ARNP), physician assistant (PA), midwife, or dentist who is licensed and provided with prescription authority from the jurisdiction of their practice can 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 1-800-345-1985 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 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699.

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 two (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. Refills for any prescription drug cannot be obtained until at least 50% of the drug has been used.
- **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:

- **We have an open formulary.** This means we classify ALL drugs (see page 49 for a list of specific diagnoses with medications that must be ordered through BioScripts 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

Because of their lower cost to you, we recommend that you ask your provider to prescribe Tier 1 (‘generic’) 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 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699. 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 do have to file a claim.** When you use a Plan pharmacy, you will not be responsible for submitting a claim form to the Plan. In the event of an accidental injury or medical emergency, you may utilize the services of a non-Plan pharmacy. For reimbursement, please submit an itemized claim form to:

MedImpact

10680 Trenea 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.
- **BioScrips medications.** Certain diagnoses require medications that your physician must order for you only through BioScrips. The following is a list of those diagnoses and medications:

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

Benefit Description	You pay After the calendar year deductible...
----------------------------	--

**Note: The calendar year deductible applies to almost all benefits in this Section.
We say "(No deductible)" when it does not apply.**

Covered medications and supplies	High Option	Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase except 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 Primary <u>Tier 1 – Generic</u></p>	<p>With Medicare Primary <u>Tier 1 – Generic</u></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Covered medications and supplies (cont.)	High Option	Standard Option
	\$3 per prescription/refill <u>Tier 2 – Preferred Brand</u> \$12 per prescription/refill <u>Tier 3 – Non-Preferred Brand</u> \$100 or 50% whichever costs the member less per prescription/refill	\$10 per prescription/refill <u>Tier 2 – Preferred Brand</u> \$30 per prescription/refill <u>Tier 3 – Non-Preferred Brand</u> 50% with \$40 minimum prescription price
<i>Not covered:</i> <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>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>Lost or stolen medications</i> 	<i>All charges.</i>	<i>All charges.</i>

Section 5(g) Special features

Feature	Description
Feature	High Option
<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>Services for deaf and hearing impaired</p>	<p>KPS provides the following TDD phone numbers: 360-478-6849 or toll-free 1-800-420-5699</p>
<p>Travel benefit/services overseas</p>	<p>See Section 5(d), page 43, 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: <p>KPS Health Plans Attn: Member Services PO Box 339 Bremerton, WA 98337</p> <ul style="list-style-type: none"> • If it is for prescription drugs, the bill/receipt must list the name of the drug and the amount of pills for each prescription.

Feature - continued on next page

Feature	Description
Feature (cont.)	High Option
	<ul style="list-style-type: none">• 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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option**, the calendar year deductible of \$25 per member (\$50 maximum per family) is required for the services listed under “Basic dental care” and “Major dental care”.
- 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.
- **For both High Option and Standard Option the annual maximum amount KPS will pay for all services combined is \$1,000 per member. You are responsible for all charges once this maximum is met.**
- **Under Standard Option**, only those procedures that are part of a routine dental exam are covered.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c), page 40, 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 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699 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.

Benefit Description	You Pay	
	High Option	Standard Option
Accidental injury benefit		
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. Sound natural teeth are those that do not have any restoration. (See Section 10, <i>Definitions of terms we use in this brochure</i>) 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% (No deductible)	20% (No deductible)

Dental Benefits	You Pay	
	High Option	Standard Option
Service		
Office visits	\$xx	

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option - We have 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.

Facts about this Plan's POS option

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

What is covered

All services/treatments listed in this brochure as covered.

What is not covered

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

- Durable medical equipment (DME) purchased from a non-Plan provider (e.g., DME purchased through the Internet)
- Non-emergency prescription drugs received from a non-Plan pharmacy (see Section 5(f), page 48, *Prescription drug benefits* for details)
- Expenses in excess of the Plan's allowable amount or benefit maximum (e.g., dental fee schedule amounts, \$2,500 annual durable medical equipment maximum)
- The difference between the billed amount and the amount allowed by KPS

Emergency benefits

Emergency care is always payable at the Plan provider level of benefit. Please see Section 5(d), page 43, *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 allows and the original charges.

Primary Care/Specialist Office Visit Example

For High Option

- You choose to go to a non-Plan provider for a primary care/specialist office visit and the charge is \$100.
- KPS determines that our allowable amount for a primary care/specialist 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 \$20 copayment for a primary care office visit.
- KPS applies your \$20 copayment to the \$60 adjusted allowable amount and pays the non-Plan provider \$40.
- The non-Plan provider may balance bill you \$40, the difference between the original charge of \$100 and the \$60 payments (our \$40 payment plus your \$20 copayment).

For Standard Option

- This example assumes you have used your first three (3) professional office visits and now your next primary care/specialist 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/specialist office visit and the charge is \$100.
- KPS determines that our allowable amount for a primary care/specialist 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.

High Deductible Health Plan Benefits

See page 9 for how our benefits changed this year and page 131 for a benefits summary.

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 We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. Sound natural teeth are those that do not have any restoration. (see Section 10-Definitions) 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.101

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Section 5 High Deductible Health Plan Benefits Overview

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

- HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read 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 benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699; or at our Web site at www.kpshealthplans.com.

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

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or HRA based upon your eligibility.

With this Plan, preventive care (including preventive dental care) is covered in full up to \$400 per person per year. As you receive other non-preventive medical care, you must meet the Plan’s deductible before we pay benefits according to the benefits described on pages 82-107. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow. **NOTE: If your enrollment in this HDHP becomes effective other than the first day of the month, your HSA funds will NOT become available until the first of the following month.**

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

- **Preventive care** The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), well-child care, child and adult immunizations and preventive dental care. These services are covered at 100% up to \$400 per person per year if you use a network provider and are fully described in Section 5, page 78, *Preventive care*. *You do not have to meet the deductible before using these services.*

The Plan covers tobacco cessation programs, obesity weight loss programs and nutritional guidance under *Educational classes and programs*. Please see Section 5(a), page 89, for benefit details.

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

Covered services include:

- Medical services and supplies provided by physicians and other health care professionals
- Surgical and anesthesia services provided by physicians and other health care professionals
- Hospital services; other facility or ambulance services
- Emergency services/accidents
- Mental health and substance abuse benefits
- Prescription drug benefits
- Accidental dental injury benefits

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

When you use non-Plan providers, your benefits are significantly less than if you use Plan providers. KPS will pay 60% of our allowed amount. In addition, it is your responsibility to pay the difference between any amounts billed by the non-Plan provider and the amount allowed by KPS. This is called “balance billing”.

What is covered

All services/treatments listed in this brochure as covered under the HDHP except preventive care (includes preventive dental care).

What is not covered

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

- Non-emergency prescription drugs received from a non-Plan pharmacy (see Section 5 (f), page 103, *Prescription drug benefits* for details)
- Expenses in excess of the Plan’s allowable amount or benefit maximum (e.g., preventive dental care fee schedule amounts, \$2,500 annual durable medical equipment maximum)
- The difference between the billed amount and the amount allowed by KPS

Emergency benefits

Emergency care is always payable at the in-network benefit level. Please see Section 5(d), page 99, *Emergency services/accidents* for benefit details.

• **Savings**

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 71 for more details).

Health Savings Accounts (HSA)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else’s tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2007, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$50 per month for a Self Only enrollment or \$100 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$1,500 for Self Only enrollment or \$3,000 for Self and Family enrollment. See maximum contribution information on page 73. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

NOTE: If your enrollment in this HDHP becomes effective other than the first day of the month, your HSA funds will NOT become available until the first of the following month.

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

HSA features include:

- Your HSA is administered by Wells Fargo Bank
- Your contributions to the HSA are tax deductible
- Your HSA earns tax-free interest

- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available

Important consideration if you want to participate in a Health Care Flexible

Spending Account: If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Instead, when you inform us of your coverage in an FSA, we will establish an HRA for you.

• **Health Reimbursement Arrangements (HRA)**

If you aren't eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2007, we will give you an HRA credit of \$600 per year for a Self Only enrollment and \$1,200 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- Your HRA is administered by Wells Fargo Bank
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSAs). However, you must meet FSAFEDS eligibility requirements. See *Who is eligible to enroll?* in Section 12 under The Federal Flexible Spending Account Program – FSAFEDS.

• **Catastrophic protection for out-of-pocket expenses**

Your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$5,000 per person or \$10,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4, *Your catastrophic protection out-of-pocket maximum* for more details.

• **Health education resources and account management tools**

HDHP Section 5(i), page 108, describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5 Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with Wells Fargo Bank, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	Wells Fargo is the HRA fiduciary for this Plan.
Fees	Set-up fee is paid by the HDHP. \$3.75 per month administrative fee charged by the fiduciary and taken out of the account balance until it reaches \$5,000.	Set-up fee is paid by the HDHP. \$1.10 per member per month administrative fee charged by the fiduciary is paid by the HDHP.
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare Part A or Part B • Not be claimed as a dependent on someone else's tax return • Must not have received VA benefits in the last three months • Complete and return the HSA Eligibility Worksheet to the HDHP <p>Eligibility for contributions is determined on the first day of the month.</p>	<p>You must enroll in this HDHP.</p> <ul style="list-style-type: none"> • Complete and return the HSA Eligibility Worksheet to the HDHP • Eligibility for contributions is determined on the first day of the month.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.	The entire amount of your HRA will be available to you upon your enrollment and prorated based on how long you are enrolled.

	If your enrollment effective date is other than the first of the month, the premium pass through contribution will begin the first of the following month.	If your enrollment effective date is other than the first of the month, the HRA annual credit will begin the first of the following month.
<ul style="list-style-type: none"> • Self Only enrollment 	For 2007, a monthly premium pass through of \$50 will be made by the HDHP directly into your HSA each month.	For 2007, your HRA annual credit is \$600 (prorated for length of enrollment).
<ul style="list-style-type: none"> • Self and Family enrollment 	For 2007, a monthly premium pass through of \$100 will be made by the HDHP directly into your HSA each month.	For 2007, your HRA annual credit is \$1,200 (prorated for length of enrollment).
Contributions/credits	<p>The annual maximum that can be contributed to your HSA is a combination of the HDHP premium pass through and your contribution funds.</p> <p>The combined amount may not exceed the amount of the deductible, which is \$1,500 for Self Only and \$3,000 for Self and Family. This amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA.</p> <p>For each month you are eligible for HSA contributions, if you choose to contribute to your HSA,</p> <ul style="list-style-type: none"> • The maximum allowable contribution is a combination of employee and employer funds up to the amount of the deductible of \$1,500 for Self Only or \$3,000 for Self and Family. To determine the maximum allowable contribution, take the amount of your deductible divided by 12, times the number of full months enrolled in the HDHP. Subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution to determine the amount you may contribute. 	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.</p>

	<ul style="list-style-type: none"> You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 76. 	
<ul style="list-style-type: none"> Self Only enrollment 	You may make an annual maximum contribution of \$900 if your enrollment effective date is January 1.	You cannot contribute to the HRA.
<ul style="list-style-type: none"> Self and Family enrollment 	You may make an annual maximum contribution of \$1,800 if your enrollment effective date is January 1.	You cannot contribute to the HRA.
Access funds	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> Health Savings Account debit Visa® card Withdrawal form 	<p>You can access your HRA by the following methods:</p> <ul style="list-style-type: none"> Benny™ card Withdrawal form
<p>Distributions/withdrawals</p> <ul style="list-style-type: none"> Medical 	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>
<ul style="list-style-type: none"> Non-medical 	If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.

	When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.	
Availability of funds	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • The HDHP sends you an HSA Eligibility Worksheet for you to complete and you return the completed worksheet to the HDHP. • The HDHP will forward your enrollment information to the fiduciary. 	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP
Portable	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA.</p>	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If You Have an HSA

If you have an HSA

- **Contributions**

All contributions are aggregated and cannot exceed the annual maximum contribution. You may contribute your own money to your account through payroll deductions (if available), or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. You receive tax advantages in any case. You have until April 15 of the following year to make HSA contributions for the current year.

IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was effective after January 1, 2007, you would need to deduct 1/12 of the annual maximum contribution. Contact Wells Fargo Bank at toll-free 1-866-890-8309 for more details.

- **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. In 2007, you may contribute up to \$800 in catch-up contributions. Catch-up contributions in later years increase up to a maximum of \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.

- **If you die**

If you do not have a named beneficiary, if you are married, it becomes your spouse’s HSA; otherwise, it becomes part of your taxable estate.

- **Qualified expenses**

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

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

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

- **Non-qualified expenses**

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

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

- **Minimum reimbursements from your HSA**

You can request reimbursement in any amount.

If You Have an HRA

- **Why an HRA is established**

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

- **How an HRA differs**

Please review the chart on page 71 which details the differences between an HRA and an HSA. The major differences are:

 - You cannot make contributions to an HRA
 - Funds are forfeited if you leave the HDHP
 - An HRA does not earn interest, and
 - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP.
 - Contact Wells Fargo Bank at toll-free 1-800-473-0926 for more details.

Section 5 Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible*, page 81.

Benefit Description	You pay
Preventive care, adult	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening – ultrasonography, one between the age of 65 and 75, for men with smoking history • Complete Blood Count, one annually • Total Blood Cholesterol once every 3 years • A fasting lipoprotein profile (total cholesterol, LDL, HDL and tryglycerides) 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 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 <p>Note: The office visit is covered if pap test is received on the same day; see Section 5(a) <i>Diagnostic and treatment services</i>, page 82.</p> <ul style="list-style-type: none"> • Routine mammogram – covered for women age 35 and older, as follows: <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>Nothing up to \$400 combined annual maximum for preventive care allowable charges.</p> <p>Once \$400 maximum is reached, you pay charges at the Traditional medical coverage level.</p>
<p>Routine immunizations endorsed by the Center for Disease Control and Prevention (CDC):</p> <ul style="list-style-type: none"> • Varicella (Chickenpox) – for persons age 19 to 49 	<p>Nothing</p> <p>Not subject to \$400 combined annual maximum for preventive care</p>

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
<ul style="list-style-type: none"> • Tetanus, Diphtheria and Pertussis (Tdap) – for persons age 19 to 64 • 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 vaccine, age 65 and older 	<p>Nothing</p> <p>Not subject to \$400 combined annual maximum for preventive care</p>
<ul style="list-style-type: none"> • One annual routine physical • One annual routine eye exam 	<p>Nothing up to \$400 combined annual maximum for preventive care allowable charges.</p> <p>Once \$400 maximum is reached, you pay charges at the Traditional medical coverage level.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i> 	<p><i>All charges.</i></p>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child visits for routine examinations, immunizations and care (up to age 22) 	<p>Nothing</p> <p>Not subject to \$400 combined annual maximum for preventive care</p>
<ul style="list-style-type: none"> • Examinations, such as: <ul style="list-style-type: none"> - Retinal screening exam for newborns performed by an ophthalmologist - 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 (up to age 22) 	<p>Nothing up to \$400 combined annual maximum for preventive care allowable charges.</p> <p>Once \$400 maximum is reached, you pay charges at the Traditional medical coverage level</p>
Dental Preventive Care	
<p>(Included in \$400 combined annual maximum for preventive care)</p>	

Section 5 Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% (see page 78) up to the annual limit and is not subject to the calendar year deductible. After the annual limit on in-network preventive care has been reached, additional preventive care is covered under Traditional medical coverage subject to the deductible.
- The deductible is \$1,500 per person or \$3,000 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total \$5,000 per person or \$10,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit maximum or amounts in excess of the Plan allowance).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits 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.

Benefit Description	You pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. You are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$1,500 per person or \$3,000 per family enrollment
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	<p>In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket.</p> <p>Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.</p>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion 	In-network: 20% Out-of-network: 40%
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 	In-network: 20% Out-of-network: 40%

Benefit Description	You pay After the calendar year deductible...
Maternity care	
<p>Complete maternity (obstetrical) care by a physician, certified nurse midwife, or licensed midwife for:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery (including home births) • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see Section 3 for other information. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a Cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. See Section 5(b), page 91, for circumcision benefits. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits Section 5(c), page 96, and Surgery benefits Section 5(b), page 91. • Dependent child – pregnancy, delivery and care of newborn during hospital stay is covered. 	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Routine sonograms to determine fetal age, size or sex</i> • <i>Care of a dependent child’s newborn once the mother is discharged from the hospital unless the newborn is determined to be your dependent by your personnel office</i> 	<p><i>All charges.</i></p>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Section 5(b), page 91, for surgical procedures) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms 	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>

Family planning - continued on next page

Benefit Description	You pay After the calendar year deductible...
Family planning (cont.)	
<p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic testing</i> 	<p><i>All charges.</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) 	<p>50%</p>
<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 intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (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> 	<p><i>All charges.</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges.</i></p>
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>, page 93.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis 	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Treatment therapies (cont.)	
<ul style="list-style-type: none"> • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy; preauthorization required • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>We only cover GHT when we preauthorize the treatment. Call MedImpact at 1-800-788-2949 for preauthorization. They will ask you to submit information that establishes that the GHT is medically necessary. Ask them 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 the GHT or related services and supplies. See Services requiring our prior approval in Section 3.</p>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
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>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>

Benefit Description	You pay After the calendar year deductible...
Physical and occupational therapies	
<p>Up to 60 inpatient and outpatient visits combined per year for the services of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists • licensed massage therapists (when prescribed by a qualified provider) <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>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<p>Cardiac rehabilitation is provided for up to \$1,000 following:</p> <ul style="list-style-type: none"> • Heart transplant; • Bypass surgery; • Myocardial infarction; • Heart valve repair/replacement; or • Combined heart-lung transplant 	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> • <i>Reflexology</i> • <i>Rolfing</i> 	<p><i>All charges.</i></p>
Speech therapy	
<p>Licensed speech therapist</p> <p>Note: Speech therapy is combined with 60 visits per year for the services of physical therapy and/or occupational therapy (see above).</p>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
Hearing services (testing, treatment, and supplies)	
<p>Hearing tests for children through age 17 (For routine screening hearing exams see <i>Preventive care, children</i>, page 79.)</p>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hearing tests for those over age 17</i> • <i>Hearing aids, testing and examinations for them</i> 	<p><i>All charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
Vision services (testing, treatment, and supplies)	
<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) 	In-network: 20% Out-of-network: 40%
<ul style="list-style-type: none"> Annual eye exam - adult 	Included in \$400 combined annual maximum for preventive care
<ul style="list-style-type: none"> Eye exams to determine the need for vision correction for children through age 17 (For routine screening eye exams see <i>Preventive care, children</i>, page 79.) 	In-network: 20% Out-of-network: 40%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Eyeglasses or contact lenses, except as related to accidental ocular injury or intraocular surgery</i> <i>Eye exercises and orthoptics</i> <i>Radial keratotomy and other refractive surgery</i> 	<p><i>All charges.</i></p>
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: 20% Out-of-network: 40%
<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> 	<p><i>All charges.</i></p>
Diabetic education, equipment and supplies	
<ul style="list-style-type: none"> Health Education and Training <ul style="list-style-type: none"> Nutritional guidance Medical Equipment <ul style="list-style-type: none"> Dialysis equipment Insulin pumps (requires prior authorization) Insulin infusion devices Glucometers Medically necessary orthopedic shoes & inserts Supplies other than those covered under <i>Prescription drug benefits</i> such as: <ul style="list-style-type: none"> Orthopedic and corrective shoes Arch supports Foot orthotics 	In-network: 20% Out-of-network: 40%

Diabetic education, equipment and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Diabetic education, equipment and supplies (cont.)	
<ul style="list-style-type: none"> - Heel pads and heel cups - Elastic stockings, support hose - Prosthetic replacements 	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
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 <p>Note: This benefit (except for externally worn breast prostheses and surgical bras) combined with the <i>Durable medical equipment (DME)</i> benefit 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), page 96, for payment information. See Section 5(b), page 91, for coverage of the surgery to insert the device.</p>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<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 (except for externally worn breast prostheses and surgical bras)</i> 	<p><i>All charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Hospital beds • Wheelchairs • Crutches • Walkers • Motorized wheelchairs <p>Note: This list is not complete. For more details please contact Member Services at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699.</p> <p>Note: This benefit (except for oxygen) 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>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<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> 	<p><i>All charges.</i></p>
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 precertification. Please refer to the precertification information shown in Section 3.</p> <p>Note: Therapy (physical, occupational, speech) applies towards your therapy maximum of 60 visits per calendar year.</p>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<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> 	<p><i>All charges.</i></p>

Home health services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Home health services (cont.)	
<ul style="list-style-type: none"> • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. 	All charges.
Chiropractic	
<ul style="list-style-type: none"> • Up to 12 treatments per calendar year for manipulations of the spine and extremities 	In-network: 20% Out-of-network: 40%
<i>Not covered: Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</i>	All charges.
Alternative treatments	
<ul style="list-style-type: none"> • Acupuncture – up to 12 treatments per calendar year when treatment is received by a licensed Plan provider • Naturopathic services 	In-network: 20% Out-of-network: 40%
<i>Not covered:</i> <ul style="list-style-type: none"> • Herbs prescribed by an acupuncturist or naturopath • Hypnotherapy • Biofeedback • Reflexology • Rolfing 	All charges.
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</i> benefit to a lifetime maximum of \$350 per member. 	Nothing up to lifetime maximums. Once maximums are reached you pay all additional charges.
<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"> - Cancer - Endocrine conditions - Swallowing conditions after stroke - Hyperlipidemia - Colitis - Coronary artery disease - Dysphagia - Gastritis - Inactive colon - Anorexia 	Nothing up to annual maximum. Once maximum is reached you pay all additional charges.

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible...
Educational classes and programs (cont.)	
<ul style="list-style-type: none"> - Bulimia - Short bowel syndrome (post surgery) - Food allergies or intolerances - Obesity <p>Up to \$400 maximum per member per year.</p>	<p>Nothing up to annual maximum.</p> <p>Once maximum is reached you pay all additional charges.</p>
<i>Not covered: Over-the-counter drugs</i>	<i>All charges.</i>
Sleep disorders	
<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 purposes 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 your provider. Preauthorization of sleep studies is not required; however, you must be referred to the sleep studies program by your 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. <p>Coverage for the medically necessary surgical treatment of diagnosed sleep disorders is covered under this benefit. Preauthorization of surgical procedures for the treatment of sleep disorders is required. Surgical treatment includes all professional and facility fees related to the surgical treatment including pre- and post-operative care and complications.</p>	<p>50%</p>
<i>Not covered: Any service not listed above for the purpose of studying, monitoring and/or treating sleep disorders.</i>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...
Temporomandibular joint (TMJ) disorders	
Treatment of TMJ, including surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy.	In-network: 20% Out-of-network: 40%
<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>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible...
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <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 <i>Reconstructive surgery</i>) • Insertion of internal prosthetic devices (See Section 5(a), <i>Orthopedic and prosthetic devices</i>, page 87, for device coverage information.) • Circumcision from birth to one month old or as medically necessary • 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 Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	
<ul style="list-style-type: none"> Surgical treatment (bariatric surgery) and all services associated with the 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 <p>Note: The surgical candidate must be at least 18 years or older, have a Body Mass Index (BMI) of greater than 40 or 35 with at least two of the following comorbidities: sleep apnea, diabetes, hypertension, coronary artery disease and hyperlipidemia. All inpatient and outpatient surgical treatment for morbid obesity must be preauthorized. See Services requiring prior approval in Section 3.</p>	50%
<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; see Section 5(a), page 86, Foot care</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; and webbed fingers and toes. All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> surgery to produce a symmetrical appearance of breasts; treatment of any physical complications, such as lymphedemas; breast prostheses and surgical bras and replacements (see Section 5(a), page 87, <i>Orthopedic and prosthetic devices</i>) <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>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>

Benefit Description	You pay After the calendar year deductible...
Reconstructive surgery (cont.)	
<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> 	<p><i>All charges.</i></p>
Oral and maxillofacial surgery	
<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. 	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<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> 	<p><i>All charges.</i></p>
Organ/tissue transplants	
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <ul style="list-style-type: none"> - Small intestine) - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas 	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses (the medical necessity limitation is considered satisfied if the patient meets the staging description):</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) <p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma 	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Amyloidosis - Ependymoblastoma - Ewing’s sarcoma - Medulloblastoma - Pineoblastoma 	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic lymphocytic leukemia - Chronic myelogenous leukemia • Autologous transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • National Transplant Program (NTP) <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as a covered benefit 	<p><i>All charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
Anesthesia	
Professional services provided in – <ul style="list-style-type: none">• Hospital (inpatient)• Hospital outpatient department• Skilled nursing facility• Ambulatory surgical center• Office	In-network: 20% Out-of-network: 40%

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) and (b), pages 82 and 91.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Inpatient hospital	
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.	In-network: 20% Out-of-network: 40%
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, birthing centers 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 (except medications) • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) • Private nursing care 	In-network: 20% Out-of-network: 40%

Benefit Description	You Pay
Inpatient hospital (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Take home medications 	<p><i>All charges.</i></p>
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>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<p><i>Not covered: Take home medications</i></p>	<p><i>All charges.</i></p>
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 preauthorization by our medical director.</p>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<p><i>Not covered: Custodial care</i></p>	<p><i>All charges.</i></p>
Hospice care	
<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>In-network: 20%</p> <p>Out-of-network: 40%</p>

Hospice care - continued on next page

Benefit Description	You Pay
Hospice care (cont.)	
<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; <p>or</p> <ul style="list-style-type: none"> • 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>	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges.</i></p>
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>	<p>20%</p>
<p><i>Not covered: The use of any type of ambulance transportation for personal convenience.</i></p>	<p><i>All charges.</i></p>

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

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.

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

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

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

Follow-up care received from non-Plan providers and/or at a non-Plan facility when the care could be received from a Plan provider and/or at a Plan facility, will be covered at the out-of-network benefit level.

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient in a hospital, including doctors’ services 	20%
<i>Not covered: Elective care or non-emergency care</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 • Emergency care as an outpatient or inpatient in a hospital, including doctors’ services 	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>
Ambulance	
<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 or 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), page 98, for non-emergency service.</p>	20%
<i>Not covered: The use of any type of ambulance transportation for personal convenience.</i>	<i>All charges.</i>

Section 5(e) Mental health and substance abuse benefits

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits	
<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>
<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 • Diagnostic tests • 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 	<p>In-network: 20%</p> <p>Out-of-network: 40%</p>
<p><i>Not covered: Services we have not approved.</i></p>	<p><i>All charges.</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	
<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>	<i>All charges.</i>

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network 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 1-800-223-6114 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

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 105.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A physician, podiatrist, advanced registered nurse practitioner (ARNP), physician assistant (PA), midwife or dentist who is licensed and provided with prescription authority from the jurisdiction of their practice can write your prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy except for 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 1-800-345-1985 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 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699.

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 two (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. Refills for any prescription drug cannot be obtained until at least 50% of the drug has been used.
- **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:

- **We have an open formulary.** This means we classify ALL drugs (see below for a list of specific diagnoses with medications that must be ordered through BioScrips 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

Because of their lower cost to you, we recommend that you ask your provider to prescribe Tier 1 (‘generic’) 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 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699. 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 do have to file a claim.** When you use a Plan pharmacy, you will not be responsible for submitting a claim form to the Plan. In the event of an accidental injury or medical emergency, you may utilize the services of a non-Plan pharmacy. For reimbursement, 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.
- **BioScrips medications.** Certain diagnoses require medications that your physician must order for you only through BioScrips. The following is a list of those diagnoses and medications:

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

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase except 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>Tier 1 – Generic \$10 per prescription/refill</p> <p>Tier 2 – Preferred Brand \$30 per prescription/refill</p> <p>Tier 3 – Non-Preferred Brand 50% with a \$40 minimum prescription price</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> 	<p><i>All charges.</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	
<ul style="list-style-type: none"> • <i>Non-prenatal vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Non-prescription 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>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>Lost or stolen medications</i> 	<p><i>All charges.</i></p>

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>Services for deaf and hearing impaired</p>	<p>KPS provides the following TDD phone numbers: 360-478-6849 or toll-free 1-800-420-5699</p>
<p>Travel benefit/services overseas</p>	<p>See Section 5(d), page 99, 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: <p>KPS Health Plans Attn: Member Services P.O. Box 339 Bremerton, WA 98337</p> <ul style="list-style-type: none"> • 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.

Feature - continued on next page

Feature	Description
Feature (cont.)	
	<ul style="list-style-type: none">• Provide proof of travel (airline ticket, passport, etc).

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c), page 96, for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. Sound natural teeth are those that do not have any restoration. (see Section 10-Definitions) The need for these services must result from an accidental injury (not biting or chewing). All services must be performed and completed within 12 months of the date of injury.	In-network: 20% Out-of-network: 40%
Dental benefits	You Pay
See <i>Dental preventive care</i> , page 79. We have no other dental benefits.	

Section 5(i) Health education resources and account management tools

Special features	Description
<p>Health education resources</p>	<p>Visit our Web site at www.kpshealthplans.com for information on:</p> <ul style="list-style-type: none"> • General health topics • Links to health care news • Cancer and other specific diseases • Drugs/medication interactions • Kids’ health • Patient safety information • and several helpful Web site links
<p>Account management tools</p>	<p>For each HSA and HRA account holder, complete payment history and balance information can be found online through www.wfhbs.com.</p> <p>This information is also available by calling the Wells Fargo HSA customer service line at 1-866-890-8309 or HRA customer service line at 1-800-473-0926.</p> <p>You will receive a quarterly statement outlining your account balance and activity for the previous quarter.</p> <p>You will also receive an explanation of benefits (EOB) after every manual (non-debit card) transaction where a check is issued or funds are direct deposited.</p> <p>If you have an HSA, you may also change your investment options online at www.wfhbs.com.</p>
<p>Consumer choice information</p>	<p>As a member of this HDHP, you may choose any provider. However, you will pay less out-of-pocket when using a network provider. Directories are available online at www.kpshealthplans.com. See pages 6 and 10 for further information.</p> <p>Pricing information for prescription drugs is available at www.kpshealthplans.com.</p> <p>Link to online pharmacy through www.kpshealthplans.com/pharmacy/pharmacy.htm.</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.wfhbs.com.</p>
<p>Care support</p>	<p>Patient safety information is available online at www.kpshealthplans.com.</p>

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 and we agree, as discussed under *Services requiring our prior approval* on page 12.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary as determined by the Plan;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices as determined by the Plan (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; 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 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699.

When you must file a claim – such as for services you receive outside 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, WA98337

Prescription drugs

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

- Covered member’s name and ID number;
- Name of the pharmacy;
- Dates you received the prescriptions;
- Name of each prescription;
- The charge for each prescription; and
- Receipts, if you paid for your prescriptions.

Submit your claims to: MedImpact

10680 Trenea Street, 5th floor

San Diego, CA92131

Deadline for filing your claim

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

When we need more information

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

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: ; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
- 2** We have 30 days from the date we receive your request to:
 - 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** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

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

We will write to you with our decision.
- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

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

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

 - A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
 - Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
 - Copies of all letters you sent to us about the claim;
 - Copies of all letters we sent to you about the claim; and
 - Your daytime phone number and the best time to call.

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

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

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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 precertification or prior approval. This is the only deadline that may not be extended.

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

You may not 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 preauthorization/prior approval, then call us at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 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 any other health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage”.
- When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.
- When we are the primary payer, we will pay the benefits described in this brochure.
- When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. When we are the secondary payer, we will coordinate benefits with the primary payer allowing up to our plan’s benefit visit maximum.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

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

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information

and decide if it makes sense for you to buy the Medicare Part B coverage.

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

- **The Original Medicare Plan (Part A or Part B)**

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. In most cases, providers and facilities will file claims with KPS on your behalf. If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

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

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

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired call TDD 360-478-6849 or toll-free 1-800-420-5699 or see our Web site at www.kpshealthplans.com.

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 Prescription Drug Benefit copayments per prescription or per refill will still apply.

- If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.
- If you enroll in a Medicare Advantage plan, the following options are available to you:

- **Medicare Advantage (Part C)**

- **This Plan and another plan’s Medicare Advantage plan:** You may enroll in another plan’s Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan’s network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.
- **Suspended FEHB coverage to enroll in a Medicare Advantage plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan’s service area.

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

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

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 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.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

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

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

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. You may also be responsible for additional amounts. See page 14.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 14.
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, and 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 14.
Experimental or investigational service	<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 post-marketing 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	<p>A service or supply which meets all of the following criteria:</p> <ol style="list-style-type: none">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 (except dentists) agree not to bill you for any charges above our allowance.

2) **Non-Plan providers:**

- **Under High and Standard Option,** 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), page 64, for Point-of-Service benefit details.
- **Under the HDHP,** we pay 60% of our allowance when you see a non-Plan provider, except in an emergency (see *Out-of-network services*, page 68). You are responsible for all charges above our allowance.

Us/We

Us and We refer to KPS Health Plans.

You

You refers to the enrollee and each covered family member.

High Deductible Health Plan (HDHP) Definitions

Benny™ card

The debit card issued to HRA enrollees by Wells Fargo. It may be used for allowable services (e.g., prescription drugs) wherever Visa is accepted. Call the Wells Fargo HSA customer service line at 1-866-890-8309 or HRA customer service line at 1-800-473-0926 for more information.

Calendar year deductible

The fixed amount of covered expenses you must incur during the calendar year for certain covered services and supplies before we start paying benefits for those services. See page 14 for more information.

Catastrophic limit

The maximum amount you will have to pay in a calendar year towards copayments, coinsurance and deductible for certain covered services. See page 70 for more information.

Health Reimbursement Arrangement (HRA)

An HRA allows you to pay for certain medical expenses using funds contributed by the Plan. Money left at the end of the year may be rolled over to the following year as long as you remain with the Plan. See page 70 for more information.

Health Savings Account (HSA)

An HSA allows you to pay for certain medical expenses using funds contributed by the Plan and/or yourself as long as you are covered only by a High Deductible Health Plan (HDHP). Money left at the end of the year may be rolled over to the following year and remains yours even if you leave the Plan. See page 69 for more information.

Premium contribution to HSA/HRA

The amount of money from your premium payment that the Plan contributes to your HSA or HRA account. See page 72 for more information.

Section 11 FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

See www.opm.gov/insure/health for enrollment information as well as:

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

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

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

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

• **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2006 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

• **When you retire**

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

When you lose benefits

• **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

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

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

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

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

- **Converting to individual coverage**

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

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

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

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

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

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

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

Section 12 Three Federal Programs complement FEHB benefits

Important information

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

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

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

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

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

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.

- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

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

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

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

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

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

When can I enroll?

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

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

Who is SHPS?

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

Who is BENEFEDS?

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

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

Important Information

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

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

Dental Insurance

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.

- Class C (Major) services, which include Endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with a 24-month waiting period

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

Vision Insurance

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

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

What plans are available?

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

Premiums

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

Who is eligible to enroll?

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

Enrollment types available

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

Which family members are eligible to enroll?

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

When can I enroll?

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

How do I enroll?

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

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

When will coverage be effective?

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

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

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

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information will reduce your out-of-pocket cost.

Summary of benefits for the High Option of KPS Health Plans - 2007

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$20	20
Services provided by a hospital:		
• Inpatient	20%	40
• Outpatient	20%	41
Emergency benefits:		
• In-area	Emergency Room: \$75 copay	44
• In-area	Urgent Care: \$20 copay	44
• Out-of-area	Emergency Room: \$75 copay	44
• Out-of-area	Urgent Care: \$20 copay	44
Mental health and substance abuse treatment:	Regular cost sharing	46
Prescription drugs:		
• Retail pharmacy	Tier 1: \$5 Medicare Primary: \$3 Tier 2: \$20 Medicare Primary: \$12 Tier 3: \$100 or 50% whichever is less	50
• Mail order (per 90 day supply)	Tier 1: \$10 Medicare Primary: \$6 Tier 2: \$40 Medicare Primary: \$24	48
Dental care:		
• Preventive dental care	All charges in excess of the fee schedule allowance.	54
• Basic dental care	\$25 per person or \$50 per family deductible, then all charges in excess of the fee schedule allowance. All charges in excess of the \$1,000 annual maximum per member for all services combined.	55
Vision care:		
• Annual eye exam - adult	Office visit copay: \$20	27

• Routine screening eye exams for children through age 17	Nothing	23
Special features:	See Section 5(g)	52
Point of Service benefits:	See Section 5(i)	64
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$5,000/person or \$5,000/family per year.	16
	Some costs do not count toward this protection	

Summary of benefits for the Standard Option of KPS Health Plans - 2007

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- **If you want to enroll or change your enrollment in this Plan,** be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the \$350 per person (\$700 per family) calendar year deductible.

Standard Option Benefits	You Pay	You Pay
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$15 copayment for first three (3) professional office visits. For all subsequent visits 20% coinsurance applies.*	20
Services provided by a hospital:		
• Inpatient	20%*	40
• Outpatient	20%*	41
Emergency benefits:		
• In-area	Emergency Room: 20%*	44
• In-area	Urgent Care: 20%*	44
• Out-of-area	Emergency Room: 20%*	44
• Out-of-area	Urgent Care: 20%*	44
Mental health and substance abuse treatment:	Regular cost sharing*	46
Prescription drugs:		
• Retail pharmacy	Tier 1: \$10 Tier 2: \$30 Tier 3: 50% with \$40 minimum prescription price	50
• Mail order (per 90day supply)	Tier 1: \$20 Tier 2: \$60	48
Dental care:		
• Preventive dental care	All charges in excess of the fee schedule allowance.	54
• Basic dental care	No benefit	55
Vision care:		
• Annual eye exam - adult	20%*	27

• Routine screening eye exams for children through age 17	20%*	23
Special features:	See Section 5(g)	52
Point of Service benefits:	See Section 5(i)	64
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$5,000/person or \$5,000/family per year. Some costs do not count toward this protection	16

Summary of benefits for the HDHP of KPS Health Plans - 2007

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 detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2007 for each month you are eligible for the HSA, KPS will deposit \$50 per month for Self Only enrollment or \$100 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), once you satisfy your Self Only \$1,500 calendar year deductible or Self and Family \$3,000 calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$600 for Self Only and \$1,200 for Self and Family. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (*) means the item is subject to the \$1,500 calendar year deductible.

HDHP Benefits	You Pay	Page
In-network medical and dental preventive care	Nothing for medical preventive care up to \$400 annual maximum; and all charges in excess of the fee schedule amount for dental preventive care	78
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	In-network: 20%* Out-of-network: 40%*	82
Services provided by a hospital:		
• Inpatient	In-network: 20%* Out-of-network: 40%*	96
• Outpatient	In-network: 20%* Out-of-network: 40%*	97
Emergency benefits:		
• In-area	20%*	100
• Out-of-area	20%*	100
Mental health and substance abuse treatment:	In-network: 20%* Out-of-network: 40%*	101
Prescription drugs:		
• Retail pharmacy	Tier 1: \$10* Tier 2: \$30* Tier 3: 50% with \$40 minimum prescription price*	105
• Mail order (per 90 day supply)	Tier 1: \$20* Tier 2: \$60*	103
Dental care - Accidental injury only:	In-network: 20%* Out-of-network: 40%*	107

Vision care:		
• Annual eye exam - adult	Nothing (included in \$400 combined annual maximum for preventive care)	79
• Routine screening eye exams for children through age 17	Nothing (included in \$400 combined annual maximum for preventive care)	79
Special features:	See Section 5(g)	106
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$5,000/person or \$10,000/family per year Some costs do not count toward this protection	16

2007 Rate Information for KPS Health Plans

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

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

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	VT1	141.92	67.89	307.49	147.10	167.54	42.27
High Option Self and Family	VT2	321.89	136.57	697.43	295.90	380.01	78.45
Standard Option Self Only	L11	128.87	42.95	279.21	93.07	152.49	19.33
Standard Option Self and Family	L12	278.14	92.71	602.63	200.88	329.13	41.72
HDHP Option Self Only	L14	106.91	35.64	231.65	77.21	126.51	16.04
HDHP Option Self and Family	L15	233.62	77.87	506.18	168.72	276.45	35.04