Kaiser Foundation Health Plan, Inc.
Southern California Region

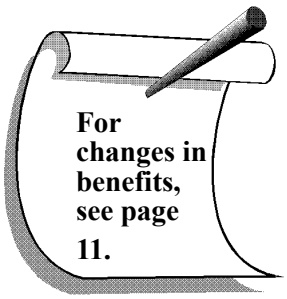
http://kp.org/feds

KAISER PERMANENTE®

2012

A Health Maintenance Organization (High and Standard Options)

Serving: *Southern California service area*



Enrollment in this Plan is limited. You must live or work in our geographic service areas to enroll. See page 8 for requirements.

This Plan has excellent accreditation from the NCQA.
See the 2012 Guide for more information on accreditation.

Enrollment codes for this Plan:

High Option
621 Self Only
622 Self and Family

Standard Option
624 Self Only
625 Self and Family

Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from Kaiser Foundation Health Plan, Inc., Southern California Region
About Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low-Income Benefits

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

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

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

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Introduction

This brochure describes the benefits of Kaiser Foundation Health Plan, Inc. - Southern California Region, under our contract (CS1044-B) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The Southern California Region's administrative office address is:

Kaiser Foundation Health Plan, Inc.
393 E. Walnut St., Pasadena, CA 91188

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, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 11. Rates are shown on the back cover of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" or "Plan" means *Kaiser Foundation Health Plan, Inc., Southern California Region.*
- 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 fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 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 (FEHB) premium.

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOB) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- 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 our Member Service Call Center at 1-800-464-4000 (TTY 1-800-777-1370) and explain the situation.
  - If we do not resolve the issue:

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

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

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

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.

- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

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

When you enter a Plan hospital for a covered service, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events" (See Section 10, Definitions of terms we use in this brochure). When a Never Event occurs you may not incur cost sharing. If you are charged a cost share for a never event that occurs at a Plan provider while you are receiving an inpatient covered service, or for treatment to correct a never event that occurred at a Plan provider, please notify the Plan.

Section 1. Facts about this HMO Plan

Kaiser Foundation Health Plan, Inc. (Plan) is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. Our Plan providers coordinate your health care services. We are solely responsible for the selection of Plan providers in your area. Contact us for a copy of our most recent provider directory. We emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment. We give you a choice of enrollment in a High Option or Standard Option.

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

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

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply may be directed to us at 1-800-464-4000. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our High and Standard Options

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing.

Your rights

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

- We are a health maintenance organization that has provided health care services to Californians since 1945.
- This medical benefit plan is provided by Kaiser Foundation Health Plan, Inc. Medical and hospital services are provided through our integrated health care delivery organization known as Kaiser Permanente. Kaiser Permanente is composed of Kaiser Foundation Health Plan, Inc. (a not-for-profit organization), Kaiser Foundation Hospitals (a not-for-profit organization), and the Southern California Permanente Medical Group (a for-profit California-based partnership) which operates Plan medical offices throughout Southern California.

If you want more information about us, call 1-800-464-4000, or write to Kaiser Foundation Health Plan, Inc., Customer Service Center, 393 E. Walnut St., Pasadena, CA, 91188. You may also visit our Web site at http://kp.org/feds.

Your medical and claims records are confidential

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

Language interpretation services

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

Service Area

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

Southern California counties:

Orange is within our service area.

Portions of the following counties, as indicated by the ZIP codes below, are also within the service area:

Imperial:	92274-75
Kern:	93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
Los Angeles:	90001-84, 90086-91, 90093-96, 90101, 90103, 90189, 90201-02, 90209-13, 90220-24, 90230-33, 90239-42, 90245, 90247-51, 90254-55, 90260-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-35, 90840, 90842, 90844, 90846-48, 90853, 90895, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-81, 91383-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-96, 91499, 91501-08, 91510, 91521-23, 91601-12, 91614-18, 91702, 91706, 91709, 91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91765-73, 91775-76, 91778, 91780, 91788-93, 91795, 91801-04, 91896, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
Riverside:	91752, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253-55, 92258, 92260-64, 92270, 92274, 92276, 92282, 92292, 92320, 92324, 92373, 92399, 92501-09, 92513-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599, 92860, 92877-83
San Bernardino:	91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 91792, 92252, 92256, 92268, 92277-78, 92284-86, 92305, 92307-08, 92313-18, 92321-22, 92324-26, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-15, 92418, 92423-24, 92427, 92880
San Diego:	91901-03, 91908-17, 91921, 91931-33, 91935, 91941-47, 91950-51, 91962-63, 91976-80, 91987, 92003, 92007-11, 92013-14, 92018-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-61, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-86, 92088, 92091-93, 92096, 92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-79, 92182, 92184, 92186-87, 92190-99
Ventura:	90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, 93099, 93252

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

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

Section 2. How we change for 2012

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

Program-wide changes

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to High Option only

- Your share of the non-Postal premium will increase for Self Only or for Self and Family. See page 86.
- We have decreased your copayment from $15 to $10 for primary care visits and increased your copayment from $15 to $20 for specialty care visits. For physical, occupational and speech therapies, urgent care at an urgent care center, individual mental health office visits, you pay the same cost sharing as for primary care visits. The specialty care office visit copayment applies to genetic counseling, allergy care testing and treatment, respiratory and inhalation therapy, certain treatment therapies, vision services, alternative treatments, insertion of internal prosthetic devices, reconstructive surgery to correct a functional defect, oral and maxillofacial surgery, and organ/tissue transplants. Foot care and certain surgical procedures may be provided by a primary care or specialty care physician. See pages 23 to 43.
- We have decreased your copayment for the diagnosis and treatment of psychiatric conditions and alcohol and drug abuse from $15 to $10 for individual office visits, and for group visits for the diagnosis and treatment of psychiatric conditions from $7 to $5 per visit. See page 50.
- We have decreased your copayment for family planning, except genetic counseling, from $15 to no charge. See page 26.
- We have decreased your copayment for eye refractions from $15 to no charge. See page 30.
- We have decreased your copayment for hearing exams to determine the need for hearing correction from $15 per office visit to no charge. See page 24.
- We have decreased your copayment from $250 per admission to no charge for hospital alternative services, such as partial hospitalization and intensive outpatient psychiatric treatment programs, and for methadone treatment for a pregnant woman throughout the pregnancy and for two months after delivery. See page 51.
- We have increased your copayment for vaccines and immunizations approved for use by the Food and Drug Administration from nothing to $10 for generic drugs and $30 for brand name drugs for up to a 30-day supply. See page 54.

Changes to Standard Option only

- Your share of the non-Postal premium will increase for Self Only or for Self and Family. See page 86.
- We have decreased your copayment from $30 to $20 for primary care visits and increased the copayment from $30 to $40 for specialty care visits. For physical, occupational and speech therapies, urgent care at an urgent care center, individual mental health office visits, you pay the same cost sharing as for primary care visits. The specialty care office visit copayment applies to genetic counseling, allergy care testing and treatment, respiratory and inhalation therapy, certain treatment therapies, vision services, alternative treatments, insertion of internal prosthetic devices, reconstructive surgery to correct a functional defect, oral and maxillofacial surgery, and organ/tissue transplants. Foot care and certain surgical procedures may be provided by a primary care or specialty care physician. See pages 23 to 43.
- We have decreased your copayment for family planning, except genetic counseling, from $30 to no charge. See page 26.
- We have decreased your copayment for eye refractions $30 to no charge. See page 30.
- We have decreased your copayment for hearing exams to determine the need for hearing correction from $30 per office visit to no charge. See page 24.

- We have decreased your copayment for the diagnosis and treatment of psychiatric conditions and alcohol and drug abuse from $30 to $20 for individual office visits, and for group visits for the diagnosis and treatment of psychiatric conditions from $15 to $10 per visit. See page 50.
- We have decreased your copayment from $500 per admission to no charge for hospital alternative services, such as partial hospitalization and intensive outpatient psychiatric treatment programs, and for methadone treatment for a pregnant woman throughout the pregnancy and for two months after delivery. See page 51.
- We have increased your copayment for vaccines and immunizations approved for use by the Food and Drug Administration from nothing to $15 for generic drugs and $35 for brand name drugs for up to a 30-day supply. See page 54.

Changes to both High and Standard Options

- Kaiser Foundation Health Plan, Inc. has two separate service areas in California ("Northern California Region" and "Southern California Region"). Kaiser Foundation Health Plan, Inc. - Southern California Region is now in a separate brochure with different rates and benefits. You must live or work in the Southern California Region service area to enroll in this Plan (enrollment code 62). If you are enrolled in this Plan, you are entitled to the benefits described in this brochure (RI 73-822).
- We have decreased your copayment for routine maternity care and the first postpartum visit from $5 to no charge. See page 26.
- We have clarified that you pay nothing for laboratory tests to monitor the effectiveness of dialysis. See page 23.
- We have clarified that you pay nothing for one routine office visit per month with the multidisciplinary nephrology team. See page 28.
- We have clarified that you pay nothing for hematopoietic agents for dialysis. See page 54.
- We have clarified that the 90-day limit on visiting member care in a different Kaiser Foundation Health Plan or allied plan services area will not apply to any member who attends an accredited college or accredited vocational school. See page 58.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call our Member Service Call Center at 1-800-464-4000 (TTY 1-800-777-1370). After registering on our Web site at http://kp.org/feds, you may also request replacement cards electronically.

Where you get covered care

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

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We contract with the Southern California Permanente Medical Group (Medical Group) to provide or arrange covered services for our members. Medical care is provided through physicians, nurse practitioners, physician assistants, and other skilled medical personnel. Specialists in most major specialties are available as part of the medical teams for consultation and treatment. Other necessary medical care, such as physical therapy, laboratory and X-ray services, is also available. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. Directories are available at the time of enrollment or upon request by calling our Member Service Call Center at 1-800-464-4000 (TTY 1-800-777-1370). The list is also on our Web site at http://kp.org/feds.

- **Plan facilities**

Plan facilities are hospitals, medical offices, and other facilities in our service area that we own or contract with to provide covered services to our members. Kaiser Permanente offers comprehensive health care at Plan facilities conveniently located throughout our service areas.

We list Plan facilities in the facility directory, with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling our Member Service Call Center at 1-800-464-4000 (TTY 1-800-777-1370).The list is also on our Web site at http://kp.org/feds.

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

What you must do to get covered care

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

To choose or change your primary care physician, you can either select one from our Provider Directory, from our Web site, http://kp.org/feds, or you can call our Member Services Call Center at 1-800-464-4000 (TTY 1-800-777-1370).

- **Primary care**

We encourage you to choose a primary care physician when you enroll. You may select a primary care physician from any of our available Plan providers who practice as generalists in these specialties: internal medicine, pediatrics, or family practice. If you do not select a primary care physician, one may be selected for you. You may choose any primary care Plan physician who is available to accept you. Parents may choose a pediatrician as the Plan physician for their child. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

Please notify us of the primary care physician you choose. If you need help choosing a primary care physician, call us. You may change your primary care physician at any time. You are free to see other Plan physicians if your primary care physician is not available and to receive care at other Kaiser Permanente facilities.

- **Specialty care**

Specialty care is care you receive from providers other than a primary care physician. When your primary care physician believes you may need specialty care, he or she will request authorization from the Plan to refer you to a specialist for an initial consultation and/or for a certain number of visits. If the Plan approves the referral, you may seek the initial consultation from the specialist to whom you were referred. You must then return to your primary care physician after the consultation, unless your referral authorizes a certain number of additional visits without the need to obtain another referral. The primary care physician must provide or obtain authorization for a specialist to provide all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you an approved referral. However, you may see Plan gynecologists, obstetricians, optometrists, or mental health and substance abuse providers without a referral. You may make appointments directly with these providers.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician, in consultation with you and your attending specialist, may develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive approved services from your current specialist until we can make arrangements for you to see a Plan specialist.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for a reason other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or
  - reduce our service area and you enroll in another FEHB plan

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Service Call Center immediately at 1-800-464-4000 (TTY 1-800-777-1370). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

For certain services your Plan physician must obtain approval from Medical Group. Before giving approval, we may consider if the service or item is medically necessary and meets other coverage requirements. We call this review and approval process "prior authorization".

Your Plan physician must obtain prior authorization for:

- Durable medical equipment (DME)
- Home health services (If your Plan Physician makes a written referral for at least eight continuous hours of home health nursing or other care, the Medical Group's designee Plan Physician or committee will authorize the Services if the designee determines that they are Medically Necessary and that they are not the types of Services that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training.)
- Organ/tissue transplants and related services
- Ostomy and urological supplies
- Services or items from non-Plan providers or at non-Plan facilities (we cover these services and items only if they are not available from Plan providers)

To confirm if your service or item requires prior authorization, please call our Member Service Call Center at 1-800-464-4000 (TTY 1-800-777-1370).

Prior authorization determinations are made based on the information available at the time the service or item is requested. We will not cover the service or item unless you are a Plan member on the date you receive the service or item.

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you at least 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

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

Emergency services do not require prior authorization. However, if you are admitted to a non-Kaiser Permanente facility, you or your family member must notify the Plan within 48 hours, or as soon as reasonably possible, or your claims may be denied.

You must obtain prior authorization from us for post-stabilization care you receive from non-Plan providers.

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

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

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

What happens when you do not follow the precertification rules

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

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

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

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

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

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

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

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

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your cost for covered services

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

Copayments

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

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

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

- Under the High Option Plan, you pay a $10 copayment when you receive diagnostic and treatment services from a primary care provider or a $20 copayment when you receive diagnostic and treatment services from a specialty care provider.
- Under the Standard Option Plan, you pay a $20 copayment when you receive diagnostic and treatment services from a primary care provider or a $40 copayment when you receive diagnostic and treatment services from a specialty care provider.

The Plan may allow you to designate a specialist as the physician who provides most of your health care (including services that primary care physicians provide, such as referrals to specialists). If you choose to receive most of your health care from a physician designated as a specialist, the specialty care office visit copayment, rather than the primary care office visit copayment, will apply.

Deductible

We do not have a deductible.

Cost-sharing

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for certain services you receive. Example: In our Plan, you pay 50% of our allowance for infertility services.

Paying cost-sharing amounts

Copayments and coinsurance are due when you receive the service, except for the following:

Before starting or continuing a course of infertility services, you may be required to pay one or more deposits toward some or the entire course of services. Any unused portion of your deposit will be returned to you. When a deposit is not required, before you can schedule an infertility procedure, you must pay the copayment or coinsurance for the procedure.

For items ordered in advance, you pay the copayment or coinsurance in effect on the order date (although we will not cover the item unless you still have plan coverage for it on the date you receive it) and you may be required to pay the copayment or coinsurance before the item is ordered.

Note: In some cases we may agree to bill you. If a physician office or Affiliated provider agrees to bill you, they may bill you an additional charge along with any unpaid copayments and coinsurance.

Your catastrophic protection out-of-pocket maximum

After your copayments and coinsurance total $1,500 per person or $3,000 per family enrollment (High Option) or $2,000 per person or $4,000 per family enrollment (Standard Option) in any calendar year, you do not have to pay any more for certain covered services. However, copayments and coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Chiropractic services
- Contraceptive devices
- Dental services
- Durable medical equipment
- Hearing aids
- Infertility services
- Prescription drugs
- Travel benefit

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

Carryover

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

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

When Government facilities bill us

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

Section 5. High and Standard Option Benefits

See page 11 for how our benefits changed this year. Page 84 and page 85 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 *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 1-800-464-4000 (TTY 1-800-777-1370) or at our Web site at http://kp.org/feds.

Since 1945, Kaiser Foundation Health Plan, Inc., Southern California Region has offered quality integrated health care to the FEHB Program. Our delivery system offers convenient, comprehensive care all under one roof. You can come to almost any one of our medical facilities and see a primary care physician or specialist, fill prescriptions, have mammograms, complete lab work, get X-rays and more. Also, our sophisticated health technology gives you the opportunity 24 hours a day, 7 days a week to schedule appointments, send secure messages to your provider, refill prescriptions, or research medical conditions.

For 2011-2012, Kaiser Permanente's Commercial HMO and Medicare HMO received "Excellent Accreditation" - the highest level of accreditation possible - from the National Committee for Quality Assurance (NCQA), a private, non-profit organization dedicated to improving health care quality.

Today, the Health Plan offers two benefit plans to Federal members, the High and Standard Options. Both Options are designed to include preventive and acute care services provided by our Plan providers, but offer different levels of benefits and services for you to choose between to best fit your health care needs.

High Option

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

- Primary care office visit copayment – $10
- Specialty care office visit copayment – $20
- Copayment on inpatient admissions – $250
- Copayment for most adult preventive care services and immunizations provided at no charge
- Drug copayments – $10 generic, $30 brand (up to a 30-day supply; up to a 100-day supply for two copayments via mail order)
- Chiropractic office visit copayment – $15 for up to 20 visits per calendar year

Standard Option

We also offer a Standard Option. With the Standard Option your copayments (and coinsurance, if appropriate) may be higher than for the High Option, but the biweekly premium is lower. Specific benefits of our FEHB Standard Option include:

- Primary care office visit copayment – $20
- Specialty care office visit copayment – $40
- Copayment on inpatient admissions – $500
- Copayment for most adult preventive care services and immunizations provided at no charge
- Drug copayments – $15 generic; $35 brand (up to a 30-day supply; up to a 100-day supply for two copayments via mail order)
- Chiropractic office visit copayment – $15 for up to 20 visits per calendar year

Please review this brochure carefully to learn which of our Kaiser Foundation Health Plan of California FEHB options is best for you. If you would like more information about our benefits, please contact us at 1-800-464-4000 (TTY 1-800-777-1370) or visit our Web site at www.kp.org.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read *Section 9* about coordinating benefits with other coverage, including with Medicare.
- Note: You will pay one-half of the individual office visit copayment for certain group office visits, rounded down to the nearest dollar.

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians and other health care professionals • In a physician's office • Office medical consultations • Second surgical opinions • In an urgent care center	$10 per primary care office visit $20 per specialty care office visit	$20 per primary care office visit $40 per specialty care office visit
Professional services of physicians and other health care professionals • During a hospital stay • In a skilled nursing facility	Nothing	Nothing
At home	Nothing	Nothing
Lab, X-ray, and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG • Nuclear medicine	Nothing	$10 per office visit
• Laboratory tests to monitor the effectiveness of dialysis	Nothing	Nothing
• CT scans/MRI • PET scans	Nothing	$50 per procedure

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

Benefit Description	You pay	
Lab, X-ray, and other diagnostic tests (cont.)	**High Option**	**Standard Option**
• Procedures requiring licensed staff to monitor your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	$50 per procedure	$200 per procedure
Preventive care, adult	**High Option**	**Standard Option**
Routine physical exam	Nothing	Nothing
Routine screenings, such as: • Total blood cholesterol • Colorectal cancer screening, including: - Fecal occult blood test - Sigmoidoscopy screening—every five years starting at age 50 - Double-contrast barium enema—every five years starting at age 50	Nothing	Nothing
• Colorectal cancer screening, including: - Colonoscopy screening—every 10 years starting at age 50	Nothing	Nothing
• Routine Prostate Specific Antigen (PSA) test one annually for men age 40 and older	Nothing	Nothing
• Routine Pap test	Nothing	Nothing
• Routine mammogram—covered for women age 35 and older, as follows: - 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, once every two consecutive calendar years Note: In addition to routine screening, we cover mammograms when medically necessary to diagnose or to treat your illness.	Nothing	Nothing
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing	Nothing
• Retinal photography screenings	Nothing	Nothing
• Hearing exams to determine the need for hearing correction	Nothing	Nothing
• Preventive services required to be covered by group health plans at no cost share by federal health care reform legislation (the Affordable Care Act and implementing regulations).	Nothing	Nothing
Notes: • You should consult with your physician to determine what is appropriate for you.		

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• You pay cost-sharing for diagnostic and treatment services for illness or injury received during a preventive care exam. See Section 5(a), *Diagnostic and treatment services.*		
Not covered: • *Physical exams required for:* - *Obtaining or continuing employment* - *Insurance or licensing* - *Participating in employee programs* - *Court ordered parole or probation*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Well-child care, including routine examinations and immunizations (through age 23 months) • Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Well-child care, including routine examinations and immunizations (age 24 months through age 17) • Examinations such as: - Eye exam through age 17 to determine the need for vision correction - Hearing screening through age 17 to determine the need for hearing correction Note: Hearing screenings are provided by a primary care physician as part of a well-child care visit. For other hearing exams or tests, see Section 5(a), *Diagnostic and treatment services* or Section 5(a), *Hearing services.*	Nothing	Nothing
• Preventive services required to be covered by group health plans at no cost share by federal health care reform legislation (the Affordable Care Act and implementing regulations).	Nothing	Nothing
Note: Should you receive services for an illness, injury or condition during a preventive care examination, you may be charged the cost-share for professional services in a physician's office. See Section 5(a), *Diagnostic and treatment services.*		
Not covered: • *Physical exams required for:* - *Obtaining or continuing employment* - *Insurance or licensing* - *Participating in employee program* - *Court ordered parole or probation*	*All charges*	*All charges*

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
• *All other hearing testing, except as may be covered in Section 5(a), Diagnostic and treatment services and Section 5(a), Hearing services*	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**
Routine maternity (obstetrical) care, such as: • Prenatal care • Delivery • First postpartum care visit Notes: • Routine maternity care is covered after confirmation of pregnancy. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision if performed after the mother's discharge from the hospital. See Section 5(b), *Surgery benefits*. • You pay cost-sharing for diagnostic and treatment services for illness or injury received during a non-routine maternity care visit. We cover surgical services (delivery) and hospitalization the same as for illness and injury. See Section 5(b), *Surgery benefits* and Section 5(c), *Hospital benefits*.	Nothing Nothing for inpatient professional delivery services	Nothing Nothing for inpatient professional delivery services
Family planning	**High Option**	**Standard Option**
A range of family planning services, limited to: • Voluntary sterilization (See Section 5(b), *Surgical procedures*) • Surgically implanted contraceptive drugs • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Family planning counseling Notes: • We cover other contraceptive drugs, cervical caps, and diaphragms. See Section 5(f), *Prescription drug benefits*. • For surgical costs associated with family planning, see Section 5(b), *Surgical procedures*.	Nothing	Nothing

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**High Option**	**Standard Option**
• Genetic counseling	$20 per specialty care office visit	$40 per specialty care office visit
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of involuntary infertility, including: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Note: See Section 5(f), *Prescription drug benefits*, for coverage of fertility drugs	50% of our allowance	50% of our allowance
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Assisted reproductive technology (ART) procedures, including related services and supplies, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT)* - *Sperm and eggs (whether from a member or from a donor) and services and supplies related to their procurement and storage, including freezing* • *Ovum transplants* • *Services to reverse voluntary, surgically induced infertility*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$20 per specialty care office visit	$40 per specialty care office visit
• Injections	$5 per office visit	$5 per office visit
• Serum	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*

Benefit Description	You pay	
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Section 5(b), *Organ/Tissue transplants.* • Intravenous (IV)/Infusion therapy— Home IV and antibiotic therapy	$20 for services provided by a physician Nothing for services provided by a non-physician provider	$40 for services provided by a physician Nothing for services provided by a non-physician provider
• Respiratory and inhalation therapy • Outpatient dialysis performed in a doctor's office or facility - hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. See Section 5(f), *Prescription drug benefits.*	$20 per specialty care office visit	$40 per specialty care office visit
• Ultraviolet light treatments • Home dialysis – hemodialysis and peritoneal dialysis • One routine office visit per month with the multidisciplinary nephrology team Note: After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our service area. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supplies when we are no longer covering them.	Nothing	Nothing
Not covered: • *Chemotherapy supported by a bone-marrow transplant or with stem cell support, for any diagnosis not listed as covered under Section 5(b), Organ/Tissue transplants.*	*All charges*	*All charges*
Physical and occupational therapies	**High Option**	**Standard Option**
• Physical therapy by qualified physical therapists to restore bodily function when you have a total or partial loss of bodily function due to illness or injury. • Occupational therapy by occupational therapists to assist you in resuming self-care and improved functioning in other activities of daily life when you have a total or partial loss of bodily function due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction.	$10 per visit Nothing for inpatient	$20 per visit Nothing for inpatient

Physical and occupational therapies - continued on next page

Benefit Description	You pay	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
• Multidisciplinary outpatient rehabilitation includes diagnostic and restorative services comprising a program of physical, speech, occupational, and respiratory therapy, as well as certain other items and services that are medically necessary for rehabilitation.	$10 per visit Nothing for inpatient	$20 per visit Nothing for inpatient
Not covered: • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
• Visits to a speech therapist	$10 per outpatient office visit Nothing for inpatient	$20 per outpatient office visit Nothing for inpatient
Not covered: • *Services to treat social, behavioral, or cognitive delays in speech or language development, unless medically necessary.*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing aids, including testing and examinations for them, for children through age 17 Notes: • We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. • Coverage is limited to the types and models of hearing aids furnished by the provider or vender we select. • For coverage of: - Hearing screenings, see Section 5(a), Preventive care, children and, for any other hearing testing, see Section 5 (a), Diagnostic and treatment services. - Audible prescription reading and speech generating devices, see Section 5(a), Durable medical equipment.	*All charges* in excess of $1,000 for each hearing impaired ear every 36 months	*All charges* in excess of $1,000 for each hearing impaired ear every 36 months
Not covered: • All other hearing testing, except as may be covered in Section 5(a), Diagnostic and treatment services and Section 5(a), Preventive care, children • Hearing aids, including testing and examinations for them, for all persons age 18 and over • Internally implanted hearing aids • Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids	*All charges*	*All charges*

Benefit Description	You pay	
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Diagnosis and treatment of diseases of the eye	$20 per specialty care office visit	$40 per specialty care office visit
• Eye refractions to determine the need for vision correction and provide a prescription for eyeglasses • Therapeutic contact lenses for the condition of aniridia for up to two lenses per eye, per calendar year • Up to a total of six medically necessary aphakic contact replacement lenses per eye, per calendar year to treat aphakia (absence of the crystalline lens of the eye) for children from birth through age 9	Nothing	Nothing
Not covered: • *Corrective eyeglass lenses or frames* • *Contact lenses, examinations for contact lenses or the fitting of contact lenses, except for the condition of aniridia or to treat aphakia* • *Eye surgery solely for the purpose of correcting refractive defects of the eye*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	$10 per primary care office visit $20 per specialty care office visit	$20 per primary care office visit $40 per specialty care office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained, or flat feet, or bunions or spurs; and of any instability, imbalance, or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
External prosthetic and orthotic devices , such as: • 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 • Ostomy and urological supplies • Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan physician	Nothing	Nothing

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• Special footwear for foot disfigurement due to disease, injury, or developmental disability • Enteral formula for members who require tube feeding per Medicare guidelines	Nothing	Nothing
Internal prosthetic devices, such as: • Artificial joints • Pacemakers • Cochlear implants • Osseointegrated external hearing devices • Surgically implanted breast implants following a mastectomy • Monofocal intraocular lenses following cataract removal • Repairs and replacements resulting from normal use Note: See Section 5(b), *Surgery benefits,* for coverage of the surgery to insert the device and Section 5(c), *Hospital benefits,* for inpatient hospital benefits.	Nothing	Nothing
Notes: • Orthopedic and prosthetic equipment or services must be prescribed by a Plan physician; obtained through sources designated by the Plan; and primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury. • We cover only those standard items that are adequate to meet the medical needs of the member. • For coverage of hearing aids, see Section 5(a), Hearing services.		
Not covered: • *Orthopedic and prosthetic devices and corrective shoes, except as described above* • *Foot orthotics and podiatric use devices, such as arch supports, heel pads and heel cups, except as described above* • *Multifocal intraocular lenses and intraocular lenses to correct astigmatism* • *Nonrigid supplies, such as elastic stockings and wigs* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Comfort, convenience, or luxury equipment or features* • *Repairs, adjustments, or replacements due to misuse or loss*	*All charges*	*All charges*

Benefit Description	You pay	
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option. Covered items include: • Oxygen and oxygen dispensing equipment • Hospital beds • Wheelchairs, including motorized wheelchairs when medically necessary • Crutches • Walkers • Speech generating devices • Blood glucose monitors and related supplies • Insulin pumps • Infant apnea monitors	20% of our allowance	50% of our allowance
• During a covered stay in a Plan hospital or skilled nursing facility	Nothing	Nothing
• External devices used for the treatment of sexual dysfunction	50% of our allowance	50% of our allowance
Notes: • Durable medical equipment (DME) is equipment that is prescribed by a Plan physician; obtained through sources designated by the Plan; consistent with our Plan DME formulary guidelines; intended for repeated use; primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury; designed for prolonged use; and appropriate for use in the home. • We cover only those standard items that are adequate to meet the medical needs of the member. • We may require you to return the equipment to us, or pay us the fair market price of the equipment, when it is no longer prescribed. • We only provide DME in the Plan's service areas, except we cover the following DME items if you live outside our service area when the item is dispensed at a Plan facility: - Standard curved handle cane - Standard crutches - For diabetes blood testing, blood glucose monitors and their supplies from a Plan Pharmacy - Insulin pumps and supplies to operate the pump (but not including insulin or any other drugs), after completion of training and education on the use of the pump - Nebulizers and their supplies for the treatment of pediatric asthma - Peak flow meters from a Plan Pharmacy		

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• Diabetes urine-testing supplies and insulin-administration devices other than insulin pumps are covered under your prescription drug benefit. See Section 5(f), *Prescription drug benefits.*		
Not covered: • *Audible prescription reading devices* • *Comfort, convenience, or luxury equipment or features* • *Non-medical items such as sauna baths or elevators* • *Exercise and hygiene equipment* • *Electronic monitors of the heart, lungs, or other bodily functions, except for infant apnea monitors* • *Devices to perform medical testing of bodily fluids, excretions or substances, except diabetic blood testing equipment and supplies* • *Modifications to the home or vehicle* • *Dental appliances* • *More than one piece of durable medical equipment serving essentially the same function* • *Spare or alternate use equipment* • *Repairs, adjustments, or replacements due to misuse or loss*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), physical or occupational therapist, speech therapist or home health aide • Services include oxygen therapy, intravenous therapy, and medications Notes: • We only provide these services in the Plan's service areas. • The services are covered only if you are homebound and a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home. • Services of a home health aide must be part of covered home health care and home health aide services are not covered unless you are also getting covered home health care from a licensed provider that only a licensed provider can provide.	Nothing	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*

Home health services - continued on next page

Benefit Description	You pay	
Home health services (cont.)	**High Option**	**Standard Option**
• *Custodial care* • *Personal care and hygiene items* • *Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a skilled nursing facility.*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
Up to 20 visits per calendar year, limited to: • Diagnosis and treatment of neuromusculoskeletal disorders • Laboratory tests and plain film X-rays associated with diagnosis and treatment Notes: • You may only self-refer to a participating American Specialty Health (ASH) network chiropractor. The participating chiropractor must provide, arrange or prescribe your care and appliances. • Participating chiropractors are listed in the ASH Participating Provider Directory. For a list of ASH Participating Providers, call 1-800-678-9133.	$15 per office visit	$15 per office visit
• Chiropractic appliances	*All charges* over $50 per calendar year	*All charges* over $50 per calendar year
Not covered: • *Hypnotherapy, behavior training, sleep therapy and weight programs* • *Thermography* • *Any radiological exam other than plain film studies such as magnetic resonance imaging, CT scans, bone scans, nuclear radiology* • *Treatment for non-neuromusculoskeletal disorders, including adjunctive therapy*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
• Acupuncture services, primarily for the treatment of chronic pain and nausea	$20 per specialty care office visit	$40 per specialty care office visit
Not covered: • *Massage therapy*	*All charges*	*All charges*

Benefit Description	You pay	
Educational classes and programs	**High Option**	**Standard Option**
Health education classes including: • Tobacco cessation programs, including individual, group and telephone counseling • Stress reduction • Chronic conditions, such as diabetes and asthma	Nothing	Nothing
• Individual health education visits	Nothing	Nothing
• Childhood obesity education	Nothing	Nothing
Notes: • Please call your local Health Education department or Member Services at 1-800-464-4000 for information on classes near you. • You pay nothing for over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. See Section 5(f), *Prescription drug benefits*, for important information about coverage of tobacco cessation and other drugs. • You can also participate in programs that are available through Kaiser Permanente as non-FEHB benefits. These programs may require that you pay a fee. See the end of Section 5, *Non-FEHB benefits available to Plan members.*		

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and will also determine the most medically appropriate setting for provision of care. Consult with your physician to determine what is appropriate for you.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET A REFERRAL FOR SOME SURGICAL PROCEDURES.** Please refer to the referral information shown in Section 3 to be sure which services require a referral and identify which surgeries require a referral.
- You will pay a $50 copayment (High Option) and a $200 copayment (Standard Option) for any surgical procedures performed in the medical office that require licensed staff to monitor your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and postoperative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns • Insertion of surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs) • Insertion of other implanted time-release drugs Note: We cover the cost of these drugs and devices under the prescription drug benefit (see Section 5(f)). • Surgical treatment of morbid obesity (bariatric surgery). You must:	$10 per primary care office visit when provided in the medical office $20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$20 per primary care office visit when provided in the medical office $40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
- be 18 years of age or older; and - have a Body Mass Index (BMI) of 40 or greater. If your BMI is 35 to 39.9, bariatric surgery may be covered if the Medical Group authorizes the services in accord with the Medical Group's bariatric surgery referral guidelines. The guidelines may require that another or a combination of medical condition(s) be present, such as: coronary artery disease, diabetes or sleep apnea; and - meet all other bariatric surgery referral guidelines, including but not limited to: nutritional, psychological, medical, and social readiness for surgery, and complete a Medical Group approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long-term bariatric surgery success Notes: • You should consult with your physician to determine what is appropriate for you. • A Plan physician, who is a specialist in bariatric care, must determine that the surgery is medically necessary. • If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, we will reimburse you for certain authorized and documented travel and lodging expenses as follows if: - The Medical Group gives you prior written authorization for travel and lodging reimbursement and - You send us adequate documentation including receipts. • Reimbursement benefits are subject to certain limits. Please call our Member Services Call Center at 1-800-464-4000 for more information.	$10 per primary care office visit when provided in the medical office $20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$20 per primary care office visit when provided in the medical office $40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis
• Surgical and any other procedures requiring licensed staff to monitor your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	$50 per office visit when provided in the medical office	$200 per office visit when provided in the medical office
• Insertion of internal prosthetic devices. See Section 5(a) *Orthopedic and prosthetic devices,* for device coverage information. Note: The following contraceptives devices and drugs are provided at no charge: intrauterine devices (IUDs), implanted time-release contraceptive drugs and injectable contraceptive drugs. We cover oral contraceptives, cervical caps, and diaphragms under the prescription drug benefit.	$20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis
Not covered:	*All charges*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers and toes • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery and reconstruction on the other breast to produce a symmetrical appearance; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Notes • If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction and orthodontic services that are an integral part of reconstructive surgery for cleft palate.	$20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis
• Reconstructive surgical and any other procedures requiring licensed staff to monitor your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	$50 per office visit when provided in the medical office	$200 per office visit when provided in the medical office
Not covered: • *Cosmetic surgery—any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*

Benefit Description	You pay	
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaw or facial bones • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Medical and surgical treatment of temporomandibular joint (TMJ) disorder (non-dental); and • Other surgical procedures that do not involve the teeth or their supporting structures	$20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis
• Oral surgical procedures requiring licensed staff to monitor your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	$50 per office visit when provided in the medical office	$200 per office visit when provided in the medical office
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Correction of any malocclusion not listed above* • *Dental services associated with medical treatment such as surgery, except for services related to accidental injury of teeth (See Section 5(g))*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. Refer to Section 3, *How you get care* for prior authorization procedures. Solid organ tissue transplants are limited to: • Cornea • Heart • Heart/Lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney/Pancreas • Liver • Lung: Single/bilateral	$20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Pancreas	$20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis
The following blood or marrow stem cell transplants are not subject to medical necessity review. Our denial is limited to the cytogenetics, subtype or staging of the diagnosis (e.g. acute, chronic) as appropriate for the diagnosis. Blood or marrow stem cell transplants are limited to: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Hemoglobinopathy - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis - Paroxysmal Nocturnal Hemoglobinuria • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Neuroblastoma - Amyloidosis	$20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
The following blood or marrow stem cell transplants are not subject to medical necessity review. Blood or marrow stem cell transplants for: • Allogeneic transplants for: - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for: - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors	$20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis
Limited benefits - The following autologous blood or bone marrow stem cell transplants may be provided in a National Cancer Institute (NCI) or National Institutes of Health (NIH)-approved clinical trial at a Plan-designated Center of Excellence. These limited benefits are not subject to medical necessity. • Breast cancer • Epithelial ovarian cancer • Childhood rhabdomyosarcoma • Advanced Ewing sarcoma • Advanced Childhood kidney cancers • Mantle Cell (Non-Hodgkin lymphoma)	$20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis
Mini-transplants performed in a Clinical Trial Setting (non-myeloblative, reduced intensity conditioning for member over 60 years of age). • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Chronic myelogenous leukemia - Hemoglobinopathy - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia	$20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Amyloidosis - Paroxysmal Nocturnal Hemoglobinuria • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Neuroblastoma - Amyloidosis	$20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis
Tandem transplants: Subject to medical necessity • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$20 per specialty care office visit when provided in the medical office $50 per admission when provided as an outpatient in a hospital or ambulatory surgery center $250 per admission when provided on an inpatient basis	$40 per specialty care office visit when provided in the medical office $200 per admission when provided as an outpatient in a hospital or ambulatory surgery center $500 per admission when provided on an inpatient basis
Transplant services requiring licensed staff to monitor your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	$50 per office visit when provided in the medical office	$200 per office visit when provided in the medical office
Notes: • We cover related medical and hospital expenses of the donor when we cover the recipient. • We cover donor screening tests for potential donors for solid organ transplants. We cover human leukocyte antigen (HLA) typing for potential donors for a bone marrow/stem cell transplant only for parents, children and siblings of the recipient. • We cover computerized national and international search expenses for prospective unrelated bone marrow/stem cell transplant donors conducted through the National Marrow Donor Program, and the testing of blood relatives of the recipient. • Please refer to Section 5(h), *Special features,* for information on our Centers of Excellence.		
Not covered: • *Donor screening tests and donor search expenses, except those listed above* • *Implants of non-human artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are covered in Sections 5(a) or (b).

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$250 per admission	$500 per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The need for anesthesia, by itself, is not such a condition.	Nothing	Nothing
Not covered: • *Custodial care and care in an intermediate care facility* • *Non-covered facilities, such as nursing homes* • *Personal comfort items, such as barber services, and guest meals and beds* • *Private nursing care, except when medically necessary* • *Inpatient dental procedures*	*All charges*	*All charges*

Benefit Description	You pay	
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Lab, X-rays, and other diagnostic tests • Blood and blood products • Pre-surgical testing • Dressing, casts, and sterile trays • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service	$50 per admission	$200 per admission
Skilled nursing care benefits	**High Option**	**Standard Option**
Up to 100 days per benefit period when you need full-time skilled nursing care. A benefit period begins when you enter a hospital or skilled nursing facility and ends when you have not been a patient in either a hospital or skilled nursing facility for 60 consecutive days. All necessary services are covered, including: • Room and board • General nursing care • Medical social services • Prescribed drugs, biological supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility	Nothing	Nothing
Not covered: • *Custodial care and care in an intermediate care facility* • *Personal comfort items, such as telephone, television, barber services, and guest meals and beds*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Supportive and palliative care for a terminally ill member: • The Services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home even if you live there temporarily) • Services are provided in the home, when a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home. • Services include inpatient care under limited circumstances, outpatient care and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately twelve months or less.	Nothing	Nothing

Hospice care - continued on next page

Benefit Description	You pay	
Hospice care (cont.)	**High Option**	**Standard Option**
Note: Hospice is a program for caring for the terminally ill patient that emphasizes supportive services, such as home care and pain and symptom control, rather than curative care. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, therapy services for purposes of safety and symptom control, physician services, palliative drugs in accord with our drug formulary guidelines, durable medical equipment (DME), and short-term inpatient care for pain control and acute and chronic symptom management. We also provide inpatient respite care, counseling and bereavement services. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.	Nothing	Nothing
Ambulance	**High Option**	**Standard Option**
• Local licensed ambulance service when medically necessary Note: See Section 5(d) for emergency services.	$50 per trip	$150 per trip
Not covered: • *Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan provider*	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is an 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.
- A psychiatric emergency is a mental disorder that manifests itself by acute symptoms of sufficient severity such that either you are in immediate danger to yourself or others, or you are not immediately able to provide for, or use, food, shelter, or clothing, due to the mental disorder.

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:

You are covered for medical emergencies anywhere in the world. In a medical emergency, call **911** or go to the nearest hospital. If you call **911,** when the operator answers, stay on the phone and answer all questions.

Emergencies within our service area:

If you think you have a medical emergency, call **911** or go to the nearest hospital. To better coordinate your emergency care, we recommend that you go to a Plan hospital if it is reasonable to do so considering your condition or symptoms. Please refer to *Your Guidebook to Kaiser Permanente Services (Guidebook)* for the location of Plan hospitals that provide emergency care.

Post-stabilization care is the services you receive after your treating physician determines that you are clinically stable. We cover post-stabilization care if a Plan provider provides it or if you obtain authorization from us to receive the care from a non-Plan provider.

When you are sick or injured, you may have an urgent care need. An urgent care need is one that requires prompt medical attention, but is not a medical emergency. If you think you may need urgent care, call the appropriate appointment or advice nurse number at a Plan facility. Please refer to the *Guidebook* for advice nurse and Plan facility telephone numbers.

Emergencies outside our service area:

If you think you have a medical emergency, call **911** or go to the nearest hospital.

Post-stabilization care is the services you receive after your treating physician determines that you are clinically stable. We cover post-stabilization care if a Plan provider provides it or if you obtain authorization from us to receive the care from a non-Plan provider.

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

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local telephone book under "Kaiser Permanente". These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling 1-800-227-2415.

How to Obtain Authorization

You must call us at 1-800-225-8883 (the telephone number is also on your ID card) to:

- Request authorization for post-stabilization care *before* you obtain the care from a non-Plan provider if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible).
- Notify us that you have been admitted to a non-Plan Hospital.

We understand that extraordinary circumstances can delay your ability to call us, for example, if you are unconscious or a young child without a parent or guardian. In these cases, you must call us as soon as it is reasonably possible. Please keep in mind that anyone can call us. We do not cover any care you receive from non-Plan providers after you're clinically stable unless we authorize it, so if you don't call us as soon as reasonably possible you increase the risk that you will have to pay for this care.

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency room visits at a Plan hospital, including physicians' services • Emergency care as an outpatient at a non-Plan hospital, including physicians' services Notes: • We waive your emergency room copayment if you are directly admitted to the hospital as an inpatient. Your inpatient admission copayment will still apply (See Section 5(c)). • Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency room copayment will not be waived.	$50 per visit	$100 per visit
Not covered: • *Elective care or non-emergency care (unless you receive prior authorization)* • *Urgent care at a non-Plan urgent care center*	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including physicians' services Note: See Section 5(h) for travel benefit coverage of continuing or follow-up care.	$50 per visit	$100 per visit
Not covered: • *Elective care or non-emergency care at non-Plan facilities (unless you receive prior authorization)*	*All charges*	*All charges*

Benefit Description	You pay	
Urgent care outside our service area	**High Option**	**Standard Option**
• Urgent care at an urgent care center	$10 per visit	$20 per visit
• Urgent care at an emergency room	$50 per visit	$100 per visit
Note: An urgent care need is one that requires prompt medical attention, but is not a medical emergency.		
Ambulance	**High Option**	**Standard Option**
Licensed ambulance services are covered when: • Your treating physician determines that you must be transported to another facility when you are not clinically stable because the care you need is not available at the treating facility. • You are not already being treated, and you reasonably believe that your condition requires ambulance transportation. Notes: • See Section 5(c) for non-emergency service. • Trip means any time an ambulance is summoned on your behalf.	$50 per trip	$150 per trip
Not covered: • *Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a provider or facility.*	*All charges*	*All charges*

Section 5(e). Mental health and substance abuse benefits

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are clinically appropriate to treat your condition.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

Professional services - continued on next page

Benefit Description	You pay	
Professional services (cont.)	**High Option**	**Standard Option**
• You may see a Plan mental health or substance abuse provider for outpatient services without a referral from your primary care physician. See Section 3, *How you get care,* for information about services requiring our prior approval. • Your Plan mental health or substance abuse provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you.		
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
• Inpatient psychiatric care • Inpatient substance abuse care Note: All inpatient admissions require approval by a Plan mental health or substance abuse physician.	$250 per admission	$500 per admission
• Recovery services for alcoholism and drug abuse in a non-medical residential care facility Note: All inpatient treatment programs require approval by a Plan physician.	$100 per stay	$100 per stay
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
• Hospital alternative services, such as partial hospitalization and intensive outpatient psychiatric treatment programs • Methadone treatment for a pregnant woman throughout the pregnancy and for two months after delivery Note: All hospital alternative services treatment programs require approval by a Plan mental health or substance abuse physician.	Nothing	Nothing
Not covered	**High Option**	**Standard Option**
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Services we have not approved* • *Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition*	*All charges*	*All charges*

Not covered - continued on next page

Benefit Description	You pay	
Not covered (cont.)	**High Option**	**Standard Option**
• *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* • *Services that are custodial in nature* • *Services rendered or billed by a school or a member of its staff* • *Services provided under a Federal, state, or local government program* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms*	*All charges*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

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

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

- **Who can write your prescription**. A licensed Plan provider or any dentist must write the prescription. Drugs prescribed by dentists are not covered if a Plan provider determines that they are not medically necessary. We cover prescriptions written by a non-Plan provider or filled at a non-Plan pharmacy only for emergencies or out-of-area urgent care.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, another pharmacy that we designate, or through our mail order program for certain maintenance medication as specified below. You may be able to order refills from a Plan Pharmacy, our mail-order program or through our Web site at www.kp.org/rxrefill. A Plan Pharmacy or Your Guidebook can give you more information about obtaining refills, including the options available to you for obtaining refills. We cover prescriptions written by a non-Plan provider or filled at a non-Plan pharmacy only for covered emergencies as specified in Section 5(d), *Emergency services/accidents*. Plan members called to active military duty (or members in time of national emergency), who need to obtain prescribed medications, should contact our Member Service Call Center at 1-800-464-4000 (TTY 1-800-777-1370) for further information regarding dispensing limitations.
- **We use a formulary.** The medications included in our drug formulary are chosen by a group of Kaiser Permanente physicians, pharmacists and other Plan providers known as the Pharmacy and Therapeutics Committee. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary based on new information or drugs that become available. We cover non-formulary drugs (those not listed on our drug formulary for your condition) prescribed by a Plan provider if they would otherwise be covered and a Plan provider determines that the drug is medically necessary. If you request the non-formulary drug when your Plan provider has prescribed a substitution, the non-formulary drug is not covered. However, you may purchase the non-formulary drug from a Plan pharmacy at prices charged to members for non-covered drugs.
- **These are the dispensing limitations.** We provide up to a 30-day supply (1 cycle of oral contraceptives) for most drugs when dispensed in a Plan pharmacy at one copayment or up to a 100-day supply (3 cycles of oral contraceptives) through our mail order program for two copayments. Drugs to treat sexual dysfunction have dispensing limitations; contact Member Services at 1-800-464-4000 for details. Mail order drugs are available anywhere in the United States. Some items are not available through mail order, for example: drugs requiring special handling, which may include professional administration or observation, medications affected by temperature (except insulin), certain drugs that have a significant potential for waste and diversion, controlled substances as determined by state and/or federal regulations, injectables and other products or dosage forms identified by the Pharmacy and Therapeutics Committee. Items available through our mail order pharmacy are subject to change at any time without notice. Drugs that have a significant potential for waste or misuse and those that a pharmacy determines are in limited supply in the market will be provided for up to a 30-day supply in any 30-day period.
- **A generic equivalent will be dispensed if it is available,** unless your Plan provider specifically requires a brand-name drug. If you request a brand-name drug when a federally approved generic drug is available, and your Plan provider has not specified the brand-name drug must be dispensed, you have to pay the full cost of the brand-name drug.
- **Why use generic drugs?** Typically generic drugs cost you and us less money than a brand-name drug. Under federal law, generic and brand-name drugs must meet the same standards for safety, purity, strength, and effectiveness.

- **When you do have to file a claim.** You do not need to file a claim when you receive drugs from a Plan pharmacy. You have to file a claim when you receive drugs from a non-Plan pharmacy for a covered emergency as specified in Section 5 (d), *Emergency services/accidents*. For information about how to file a claim, see Section 7, *Filing a claim for covered services*.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician or dentist and obtained from a Plan pharmacy or through our mail order program: • Certain self-administered IV drugs and fluids requiring specific types of parenteral infusion, and the supplies required for their administration • Hematopoietic agents for dialysis • Amino acid-modified products used to treat congenital errors of amino acid metabolism • Diabetes urine-testing supplies limited to ketone test strips, test tape and acetone test tablets, up to a 100-day supply • Elemental dietary enteral formula when used as a primary therapy for regional enteritis Note: See Section 5(a), *Durable medical equipment*, for diabetes blood-testing equipment and supplies.	Nothing	Nothing
• Drugs and medicines that, by federal law, require a prescription for their purchase, except those listed as *Not covered*. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary. • Insulin • Disposable needles and syringes for the administration of covered medications • Growth hormone • Vaccines and immunizations approved for use by the Food and Drug Administration Notes: • The brand name drug copayment will apply to compound drugs. • A compound drug is one in which two or more drugs or pharmaceutical agents are combined together. We limit coverage to products listed in our drug formulary and when one of the ingredients requires a prescription by law.	Up to a 30-day supply at $10 for generic drugs and $30 for brand name drugs *All charges* if you request a brand name drug in place of a generic drug	Up to a 30-day supply at $15 for generic drugs and $35 for brand name drugs *All charges* if you request a brand name drug in place of a generic drug
• Prescription and over-the-counter tobacco cessation drugs approved by the FDA to treat tobacco dependence	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Insulin administration devices, such as: - Disposable needles and syringes - Pen delivery devices - Visual aids required to ensure proper dosage (except eyewear) Note: See Section 5(a), *Durable medical equipment*, for coverage of insulin pumps and supplies	Up to a 100-day supply at $10	Up to a 100-day supply at $15
• Oral contraceptives • Diaphragms and cervical caps • Topical contraceptives	$10 for generic drugs (1 cycle) $30 per prescription for brand name drugs (1 cycle) *All charges* if you request a brand name drug in place of a generic drug $30 per device	$15 for generic drugs (1 cycle) $35 per prescription for brand name drugs (1 cycle) *All charges* if you request a brand name drug in place of a generic drug $35 per device
• Fertility drugs • Sexual dysfunction drugs Note: If a drug for which a prescription is required by law is excluded and we had been covering and providing it to you for a use approved by the FDA, we will continue to provide the drug upon payment of 50% of our allowance if a Plan physician continues to prescribe the drug for the same condition.	50% of our allowance	50% of our allowance
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Prescriptions filled at a non-Plan pharmacy, except for emergencies as described in Section 5(d), Emergency services/accidents* • *Vitamins, dietary and herbal supplements and formulas that can be purchased without a prescription* • *Nonprescription drugs, unless they are included in our drug formulary or listed as covered above* • *Medical supplies, such as dressings and antiseptics, except as listed above* • *Drugs that shorten the duration of the common cold* • *Any requested packaging of drugs other than the dispensing pharmacy's standard packaging*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• *Replacement of lost, stolen or damaged prescription drugs and accessories* • *Drugs related to non-covered services* • *Drugs used in the treatment of weight management* • *Drugs for the promotion, prevention, or other treatment of hair loss or growth*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures at a Plan hospital we designate only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c), *Hospital benefits*, for inpatient hospital benefits. We do not cover the dental procedure except as described below.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- No precertification is required for accidental injury to teeth. Accidental injury to teeth services may be obtained from a licensed dentist. Please submit claims for services related to accidental injury to teeth according to Section 7, *Filing a claim for covered services*, of this brochure

Benefit Description	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover services to promptly repair (but not replace) a sound, natural tooth, if: • damage is due to an accidental injury from trauma to the mouth from violent contact with an external object, • the tooth has not been restored previously, except in a proper manner, and • the tooth has not been weakened by decay, periodontal disease, or other existing dental pathology. Note: Services will be covered only when provided within 72 hours following the accidental injury.	Nothing up to the benefit maximum of $500 of covered charges per accidental injury All charges after reaching the benefit maximum of $500 per accidental injury	Nothing up to the benefit maximum of $500 of covered charges per accidental injury All charges after reaching the benefit maximum of $500 per accidental injury
Not covered: • *Services for conditions caused by an accidental injury occurring before your eligibility date.*	*All charges*	*All charges*

Dental benefits

We have no other dental benefits.

Section 5(h). Special features

Feature	Description
Feature	
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
24-hour advice line	For any of your health concerns, 24 hours a day, 7 days a week, you may talk with a registered nurse who can help assess medical symptoms and provide advice over the phone, when medically appropriate. You can obtain an advice nurse phone number for the nearest Kaiser Permanente facility in the white pages of your phone book under “Kaiser Permanente.”
Centers of Excellence	The Centers of Excellence program began in Fall 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted “Centers of Excellence” for certain specialized medical procedures. We have developed a nationally contracted network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.
Services for the deaf, hard of hearing or speech impaired	We provide a TTY/text telephone number at: 1-800-777-1370. Sign language services are also available.
Services from other Kaiser Permanente or allied plans	When you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered services, copayments, and coinsurance described in this FEHB brochure. The 90-day limit on visiting member care does not apply to members who attend an accredited college or accredited vocational school.

Feature - continued on next page

Feature	Description
Feature (cont.)	
	Please call our Member Service Call Center at 1-800-464-4000 (TTY 1-800-777-1370) to receive more information about visiting member care, including facility locations in other service areas. Service areas and facilities where you may obtain visiting member care may change at any time.
Travel benefit	Kaiser Permanente's travel benefits for Federal employees provide you with outpatient follow-up and/or continuing medical and mental health and substance abuse care when you are temporarily (for example, on a temporary work assignment or attending school) outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency services/accident benefits and include: • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast. • Outpatient continuing care for covered services for conditions diagnosed and treated within the previous 12 months by a Kaiser Permanente health care provider or affiliated Plan provider. Services include dialysis and prescription drug monitoring. You pay $25 for each follow-up and/or continuing care office visit. This amount will be deducted from the reimbursement we make to you or to the provider. We limit our payment for this travel benefit to no more than $1,200 each calendar year. For more information about this benefit, call our Member Service Call Center at 1-800-464-4000 (TTY 1-800-777-1370). File claims as shown in Section 7. *The following are a few examples of services not included in your travel benefits coverage:* • *Nonemergency hospitalization* • *Infertility treatments* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* • *Durable medical equipment (DME)* • *Prescription drugs* • *Home health services*

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all grievances must follow the Plan's guidelines. For additional information contact the Plan at 1-800-464-4000 (TTY 1-800-777-1370).

Eyewear discount (Available only to High Option members and only at Vision Essentials by Kaiser Permanente)
As a Kaiser Permanente FEHB Program member, you and your eligible dependents will be able to purchase eyewear at significant savings. When you visit any of the Vision Essentials by Kaiser Permanente Optical Centers, you will receive 25 percent off our allowance for frames and lenses and options such as no-line bifocals and prescription and non-prescription sunglasses. You will also be able to receive 25 percent off our allowance for cosmetic contact lenses and the required lens fitting.

Limitations & exclusions: This discount will apply only to purchased eyewear under the FEHBP basic coverage. The vision discount may not be coordinated with any other Kaiser Permanente Health Plan vision benefit. This discount will also not apply to any sale, promotional, or packaged eyewear program or for any contact lens Extended Purchase Agreement (which includes products purchased in this Agreement) or to low-vision aids or devices.

Expanded dental benefits

Option I: KPIC's Dental Insurance Plan: Underwritten by Kaiser Permanente Insurance Company (KPIC) and administered by Delta Dental of CA, KPIC's Dental Assistance Insurance Plan uses a Table of Allowances that allows you the freedom to see any licensed dentist of your choice. The Table of Allowances lists the dollar amount KPIC will pay for each covered dental service. Your calendar year deductible is $50 per person, up to a maximum of $150 for the family. There is no deductible on diagnostic and preventive services. KPIC's Dental Assistance Insurance Plan offers a full range of services: diagnostic, preventive, restorative, endodontics, periodontics, oral surgery, and both fixed and removable prosthodontics.

Option II: DeltaCare: DeltaCare offers dental health maintenance organization (HMO) benefits that are administered by DeltaCare USA, an affiliate of Delta Dental of CA. You select a dentist from the network of contracting DeltaCare dental offices that is most convenient for you and your family. With DeltaCare, there are no claim forms to worry about. DeltaCare also provides a full range of services that includes preventive, restorative, endodontics, periodontics, prosthetics, oral surgery, and orthodontics. Under this program, the subscriber pays a specific copayment for most covered services.

Premium*	Option I/KPIC's Dental Assistance Insurance Plan	Option II/Delta Care	Option II/DeltaCare
	Monthly Premium	Monthly Premium	Quarterly Premium
Self Only	$29.03	$11.89	$35.67
Self & One Party	$51.44	$19.90	$59.70
Self & Two or More	$77.32	$30.17	$90.51

These dental plans are not part of the FEHB contract or premium, enrollment is voluntary. Enrollment in either dental plan is for a period of one year. This does not apply if your employment is terminated. Payment for either the KPIC or PMI dental plan will be automatically withdrawn from the checking, savings, or credit union account you specify.

How to enroll
Please use the enclosed postage-paid card to send in your application. If you would like more information on either dental plan, please call:

Delta Dental: **1-888-335-8227**
KPIC Dental Assistance Insurance Plan: Federal dental group number is 9874
DeltaCare **USA**: **1-800-422-4234**
DeltaCare **USA**: Federal dental group number is 1114

* These rates are effective January 1, 2011 through December 31, 2011.

Section 6. General exclusions – things we don't cover

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

You will only need to file a claim when you receive emergency services or urgent care outside our service area from non-Plan providers or when you use the travel benefit. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Facilities will file on the UB-04 form. For claims questions and assistance, call our Member Service Call Center at 1-800-464-4000 (TTY 1800-777-1370).

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

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

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

Submit your claims to:

Southern California service area:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

Deadline for filing your claim

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

Post-Service Claims

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Binding arbitration

If you have any claim or dispute that is not governed by the Disputed Claims Process with OPM described in Section 8, then all such claims and disputes of any nature between you and the Plan, including but not limited to malpractice claims, shall be resolved by binding arbitration, subject to the Plan's Arbitration procedures. For information that describes the arbitration process. Contact our Member Service Call Center at 1-800-464-4000 for copies of our requirements. These will explain how you can begin the binding arbitration process.

Section 8. The disputed claims process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: *Kaiser Permanente, Special Services Unit, P.O. Box 7136, Pasadena, CA 91109; and* c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street NW, Washington, DC 20415-3630.

Send OPM the following information:

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

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

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

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to 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 you did not indicate that your claim was a claim for urgent care, then call us at 1-800-464-4000. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

- **When you have other health coverage**

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

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other FEHB plans, coordinate benefits with other coverage according to the National Association of Insurance Commissioners' guidelines.

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

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

- **What is Medicare?**

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983). Otherwise, if you are age 65 or older, or under age 65 and disabled, you may be able to buy it. Contact **1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048)** for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage): You may enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan, Kaiser Permanente Senior Advantage for Federal Members. Please review the information about Medicare Advantage plans on page 68.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. However, when you are enrolled in Kaiser Permanente Senior Advantage for Federal Members, Part D is included in your plan; no separate premium applies. 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 (TTY 1-800-325-0778)** to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

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

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage 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.

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

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

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-443-0815 (TTY 1-800-777-1370), 8 a.m. to 8 p.m., 7 days a week, or visit our Web site at http://kp.org/feds.

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

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at **1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048**) or at www.medicare.gov.

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

  This Plan and our Medicare Advantage plan: We offer a Medicare Advantage plan known as Kaiser Permanente Senior Advantage for Federal Members. Senior Advantage for Federal Members enhances your FEHB coverage by lowering cost-sharing for some services and/or adding benefits. If you have Medicare Parts A and B, or Medicare Part B only, you can enroll in Senior Advantage for Federal Members with no increase to your FEHB or Kaiser Permanente premium. Your enrollment is in addition to your FEHB High Option or Standard Option enrollment. If you are already a member of Senior Advantage for Federal Members and would like to understand your additional benefits in more detail, please refer to your Senior Advantage for Federal Members Evidence of Coverage. If you are considering enrolling in Senior Advantage for Federal Members, please call us at **1-800-443-0815 (TTY 1-800-777-1370)**, 8 a.m. to 8 p.m., 7 days a week, or visit our Web site at http://kp.org/feds**.**

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

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

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

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 your injuries

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

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

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

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

Clinical trials

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

- Routine care costs are costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy. We cover routine care costs not provided by the clinical trial.
- Extra care costs are costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We cover some extra care costs not provided by the clinical trial. We encourage you to contact us to discuss coverage for specific services if you participate in a clinical trial.

The Plan does not cover research costs.

- Research costs are costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. We do not cover these costs.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical trials cost categories	• Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy. • Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. • Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See Section 4.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (i.e., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting, and taking medicine. (2) Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Custodial care that lasts 90 days or more is sometimes known as long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.
Experimental or investigational services	We do not cover a service, supply, item or drug that we consider experimental, except for the limited coverage specified in Section 9, Clinical trials. We consider a service, supply, item or drug to be experimental when the service, supply, item or drug: (1) has not been approved by the FDA; or (2) is the subject of a new drug or new device application on file with the FDA; or (3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or (4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or (5) is subject to the approval or review of an Institutional Review Board; or (6) requires an informed consent that describes the service as experimental or investigational. We carefully evaluate whether a particular therapy is safe and effective or offers a reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental literature.

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

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

Medically necessary All benefits need to be medically necessary in order for them to be covered benefits. Generally, if your Plan physician provides the service in accord with the terms of this brochure, it will be considered medically necessary. However, some services are reviewed in advance of you receiving them to determine if they are medically necessary. When we review a service to determine if it is medically necessary, a Plan physician will evaluate what would happen to you if you do not receive the service. If not receiving the service would adversely affect your health, it will be considered medically necessary. The services must be a medically appropriate course of treatment for your condition. If they are not medically necessary, we will not cover the services. In case of emergency services, the services that you received will be evaluated to determine if they were medically necessary.

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

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

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

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

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

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

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or

- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

If you believe your claim qualifies as an urgent care claim, please contact our Member Service Call Center at 1-800-464-4000. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and we refer to Kaiser Foundation Health Plan, Inc., Southern California Region.

You You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

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

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self 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 of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural and adopted children are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

- **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 on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2012 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 2011 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits 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 26, 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 Benefits 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. Other Federal Programs

Important Information about three Federal programs that compliment the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

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

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

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

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

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

- **Health Care FSA (HCFSA)** - Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any 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 tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** - Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

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

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

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

Dental Insurance

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

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

Additional Information

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

How do I enroll?

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

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

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

Pre-Existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY: 1-866-561-1604).

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

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Notes

Summary of benefits for the High Option of the Kaiser Foundation Health Plan, Inc., Southern California Region - 2012

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$10 per primary care office visit $20 per specialty care office visit	23
Services provided by a hospital:		
• Inpatient	$250 per admission	44
• Outpatient	$50 per admission	45
Emergency benefits:		
• In-area	$50 per visit	48
• Out-of-area	$50 per visit	48
Mental health and substance abuse treatment:	Regular cost-sharing	50
Prescription drugs:		
• Generic drugs	$10 per prescription	54
• Brand name drugs	$30 per prescription All charges if you request a brand name drug in place of a generic drug	54
Dental care:	No benefit	57
Vision care:	Refractions; Nothing	30
Special features: Flexible benefits option; 24-hour advice line; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Travel benefit.		58
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $1,500/Self Only or $3,000/ Family enrollment per year Some costs do not count toward this protection	18

Summary of benefits for the Standard Option of the Kaiser Foundation Health Plan, Inc., Southern California Region - 2012

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

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$20 per primary care office visit $40 per specialty care office visit	23
Services provided by a hospital:		
• Inpatient	$500 per admission	44
• Outpatient	$200 per admission	45
Emergency benefits:		
• In-area	$100 per visit	48
• Out-of-area	$100 per visit	48
Mental health and substance abuse treatment:	Regular cost-sharing	50
Prescription drugs:		
• Generic drugs	$15 per prescription	54
• Brand name drugs	$35 per prescription All charges if you request a brand name drug in place of a generic drug	54
Dental care:	No benefit	57
Vision care:	Refractions; Nothing	30
Special features: Flexible benefits option; 24-hour advice line; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Travel benefit.		58
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $2,000/Self Only or $4,000/ Family enrollment per year Some costs do not count toward this protection	18

2012 Rate Information

For 2012 health premium information, please see http://www.opm.gov/insure/health/tribes/rates/ or contact your tribe's Human Resources department.