Kaiser Permanente - Georgia

www.kp.org/feds

Member Services 888-865-5813

KAISER PERMANENTE®

2024

A Health Maintenance Organization
(High Option, Standard Option and Prosper)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This plan is accredited. See page 12.

Serving: *Atlanta, Georgia metropolitan area and Athens, Columbus, Macon and Savannah service areas*

IMPORTANT
- Rates: Back Cover
- Changes for 2024: Page 14
- Summary of Benefits: Page 100

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

Enrollment codes for this Plan:

F81 High Option - Self Only
F83 High Option - Self Plus One
F82 High Option - Self and Family

F84 Standard Option - Self Only
F86 Standard Option - Self Plus One
F85 Standard Option - Self and Family

LA1 Prosper - Self Only
LA3 Prosper - Self Plus One
LA2 Prosper - Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from Kaiser Foundation Health Plan of Georgia, Inc.
About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Kaiser Foundation Health Plan of Georgia, Inc. prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all Plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Medicare's Low-Income Benefits

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

Potential Additional Premium for Medicare's High-Income Members

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. This **additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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 **800-MEDICARE (800-633-4227), (TTY: 877-486-2048)**.

Table of Contents

Introduction

This brochure describes the benefits of Kaiser Permanente - Georgia under contract (CS 2163) between Kaiser Foundation Health Plan of Georgia, Inc. and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Member Services may be reached at 404-261-2590 (locally in the metropolitan Atlanta area) or 888-865-5813 (long distance) (TTY: 711) or through our website: www.kp.org. The address for Kaiser Foundation Health Plan of Georgia, Inc. administrative offices is:

Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, Georgia 30305-1736

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or 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, 2024, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2024, and changes are summarized on page 14 Rates are shown at the end 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 and each covered family member, “we” or “Plan” means Kaiser Foundation Health Plan of Georgia, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Healthcare Fraud!

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

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

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

- Do not give your Plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOB) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 404-261-2590 (TTY: 711) and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go to: www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

Do not maintain as a family member on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

We may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment

- 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 (TCC).
- 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.

Discrimination is Against the Law

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning and understanding your risks. 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 take notes, ask questions and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosages that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for details.
- Ask what the results mean for your care.

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"

- "About how long will it take?"
- "What will happen after surgery?"
- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter a Plan hospital for treatment of one medical problem covered service, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events." (See Section 10, Definitions of terms we use in this brochure).

We have a benefit payment policy that encourages Plan hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. If you are charged a cost share for a never event that occurs while you are receiving an inpatient covered service, or for treatment to correct a never event that occurred at a Plan provider, please notify us.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

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

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

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

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

  Also, your employing or retirement office can answer your questions, give you other plans' brochures 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 do not 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.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is the enrollee, and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus one or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. We may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

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

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: 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
Coverage: 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
Coverage: 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
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

  The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2024 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2023 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 an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment.

  You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

  If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member 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 information about your coverage choices, https://www.opm.gov/healthcare- insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn 26.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if

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

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at (888) 865-5813 or visit our website at www.kp.org/feds.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Kaiser Foundation Health Plan of Georgia, Inc. holds the following accreditations: National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation, please visit the following website: www.ncqa.org.

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your healthcare services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a High Option, a Standard Option or Prosper.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

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

Questions regarding what protections apply may be directed to us at 404-261-2590 (locally in the metropolitan Atlanta area) or 888-865-5813 (long distance). 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 Option, Standard Option and Prosper

Our HMO offers a High Option, Standard Option and Prosper. Under our High and Standard Options there is no deductible and you pay a copayment for most of your covered services. Prosper has a deductible that applies to some covered services and may have higher copayments than the 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 (copayments, coinsurance, deductibles, and non-covered services and supplies).

Your rights and responsibilities

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 website (www.opm.gov/insurance-healthcare) 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 healthcare services to Georgia since 1985.
- This medical benefit plan is provided by Kaiser Foundation Health Plan of Georgia, Inc. Medical and hospital services are provided through our integrated healthcare delivery organization known as Kaiser Permanente. Kaiser Permanente is composed of Kaiser Foundation Health Plan of Georgia, Inc. (a not-for-profit organization) and The Southeast Permanente Medical Group, Inc. (a for-profit Georgia-based corporation) which provides services in Plan medical offices throughout Georgia and through participating providers.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our Kaiser Permanente Georgia website at www.kp.org/feds. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 404-261-2590 (TTY: 711), or write to Kaiser Foundation Health Plan of Georgia, Inc., Member Services Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736. You may also visit our website at www.kp.org/feds.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.kp.org/feds to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Language Interpretation Services

Language interpretation services are available to non-English speaking members. Please ask an English-speaking friend or relative to call our Member Services Department at 404-261-2590 (locally in the metropolitan Atlanta area) or 888-865-5813 (long distance) (TTY: 711).

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.

Service Area

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

Atlanta metro service area: Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton counties.

Athens service area: Clarke, Madison, Oconee, and Oglethorpe counties.

Columbus service area: Chattahoochee, Harris, Marion, and Muscogee counties.

Macon service area: Bibb, Bleckley, Crawford, Houston, Jones, Laurens, Monroe, Peach, Pulaski, and Twiggs counties.

Savannah service area: Bryan, Bulloch, Chatham, Effingham, Evans and Liberty counties.

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 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 healthcare services out of our service area unless the services have prior Plan approval.

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

Section 2. Changes for 2024

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

Changes to High Option, Standard Option, and Prosper

- **Premium.** Your share of the premium rate will increase for Self Only, Self Plus One and Self and Family. See Page 103.

Changes to High Option and Standard Option

- **Fertility drugs.** We added coverage for in vitro fertilization-related drugs when prescribed by either a Plan or a non-Plan provider. You pay 50% of our allowance. There are no lifetime dollar or cycle limits for fertility drugs. See Page 67.

Change to High Option

- **Gender-affirming surgery.** We now cover all medically necessary gender-affirming surgery including facial surgeries. You pay $150 per visit for services in an outpatient hospital or ambulatory surgical center, or $500 per admission for inpatient hospital. See Page 47.

Change to Standard Option

- **Gender-affirming surgery.** We now cover all medically necessary gender-affirming surgery including facial surgeries. You pay $200 per visit for services in an outpatient hospital or ambulatory surgical center, or $750 per admission for inpatient hospital. See Page 47.

Changes to Prosper

- **Fertility drugs.** We added coverage for fertility drugs, including in vitro fertilization-related drugs when prescribed by either a Plan or a non-Plan provider. You pay 50% of our allowance. There are no lifetime dollar or cycle limits for fertility drugs. See Page 67.
- **Preventive care.** We decreased cost-sharing from $20 per primary care office visit to no charge for screening for major depressive disorder in adolescents aged 12 to 18 and screening for anxiety in children and adolescents aged 8 to 18. See Page 31.
- **Gender-affirming surgery.** We now cover all medically necessary gender-affirming surgery including facial surgeries. You pay $250 per visit after the deductible for services in an outpatient hospital or ambulatory surgical center, or $750 per admission after the deductible for inpatient hospital. See Page 47.

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 Member Services at 404-261-2590 (locally in the metropolitan Atlanta area) or 888-865-5813 (long distance), (TTY: 711), or write to us at: Member Services Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736. After registering on our website at www.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 described in Section 4. *Your Cost for Covered Services.*

- **Balance billing protection**

FEHB Carriers must have clauses in their plan provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the plan provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If a plan provider bills you for covered services over your normal cost share (deductible, copay, co-insurance), contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We contract with The Southeast Permanente Medical Group, Inc. (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. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

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 Services Department at (404) 261-2590 (locally) or 888-865-5813 (long distance) (TTY: 711). The list is also on our website at www.kp.org/feds.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

Kaiser Permanente primary care providers provide care coordination for complex conditions, for assistance please contact your provider or member services (404) 261-2590 (locally) or 888-865-5813 (long distance) (TTY: 711).

- **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 healthcare at Plan facilities conveniently located throughout our service areas.

We list Plan facilities in the provider directory, with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling our Member Services Department at (404) 261-2590 (locally) or 888-865-5813 (long distance) (TTY: 711). The list is also on our website at www.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 healthcare 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 provider. This decision is important since your primary care provider delivers or arranges for most of your healthcare.

To choose or change your primary care provider, you can either select one from our Provider Directory, from our website, www.kp.org/feds, or you can call our Member Services Department at 404-261-2590 (locally in the metropolitan Atlanta area) or 888-865-5813 (long distance) (TTY: 711).

- **Primary care**

We encourage you to choose a Medical Group physician as your primary care provider when you enroll. You may select a primary care provider from any of our available Plan providers who practice in these specialties: internal medicine, pediatrics or family practice. If you do not select a primary care provider, one will 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 provider will provide most of your healthcare, or give you a referral to see a specialist.

Please notify us of the primary care provider you choose. If you need help choosing a primary care provider, call us or visit our website at www.kp.org/feds. You may change your primary care provider at any time. You are free to see other Plan physicians if your primary care provider 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 provider. When your primary care provider believes you may need specialty care, they 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 provider after the consultation, unless your referral authorizes a certain number of additional visits without the need to obtain another referral. The primary care provider 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 provider gives you a referral that has been approved by us. However, you may see Plan gynecologists, obstetricians, dermatologists, optometrists, ophthalmologists, mental health, and substance use providers without a referral. You may make appointments directly with these providers.

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

- Keep in mind that your primary care provider choice determines which specialists are available to you. Your primary care provider has an established relationship with a specific group of specialty care doctors. By referring only to a certain group of specialists, your primary care provider is better able to ensure that you receive quality care.
- If you change primary care provider, you must check with your new primary care provider to determine if you can continue seeing your current specialist or if you need a new referral.
- If you receive specialty care services outside the Medical Group for which a referral was not obtained, is no longer valid or is beyond the level of care authorized by us, you will be responsible for all charges associated with those services.
- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider 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 provider 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 provider. Your primary care provider will decide what treatment you need. If they decide 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 provider, 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 program plan; or
  - reduce our service area and you enroll in another FEHB plan

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

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

- **Hospital care**

Your Plan primary care provider 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 Services Department immediately at 404-261-2590 (TTY: 711). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

- you are discharged, not merely moved to an alternative care center;

- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

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

- **Rescheduling of services**

Copayments, deductibles and coinsurance for services are due at the time of your visit. We reserve the right to reschedule non-urgent care if you do not pay at the time of your visit.

You need prior Plan approval for certain services

Your primary care provider arranges most referrals to specialists. For certain services your Plan provider must obtain approval from us. Before we approve a referral, 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". Once the referral is approved, we will notify you that we have authorized your referral.

When you receive medical services for which you do not have prior authorization from us, we will not pay for them except in an emergency. Charges for these medical services will be your financial responsibility.

Your Plan provider must obtain prior authorization from us for:

- Inpatient hospital care services, surgery and procedures
- Outpatient surgery, related services and procedures
- Ambulance transport (non-emergency)
- Bariatric surgery and related services
- Gender reassignment surgery
- Clinical trials
- Dental services covered under the medical plan and temporomandibular joint treatment
- Certain prescription medications as identified on our formulary
- The following diagnostic services:
  - Sleep studies
  - Neuropsychological testing
  - Video capsule endoscopy
- Applied Behavior Analysis (ABA)
- Durable medical equipment (DME) and orthopedic and prosthetic devices
- Feeding disorder treatment
- Growth hormone therapy (GHT)
- Home health services and hospice care
- Infertility diagnosis and treatment
- Injections/infusions
- Organ/tissue transplants and related services
- Outpatient multidisciplinary rehabilitation
- Post-stabilization care
- Speech therapy
- The following radiology services:
  - CT scans

- CT angiography
- MRI
- MRA
- PET
- SPECT
- Specialty imaging

- Skilled nursing care
- The following treatment therapies:
  - Biofeedback
  - Hyperbaric oxygen (HBO) treatment
  - Pain management services
  - Sclerotherapy or other varicose vein treatment
  - Uterine artery embolization
- Wound care services
- Services or items from a non-Plan provider or at non-Plan facilities

To confirm if your referral has been approved for a service or item that requires prior authorization, please call our Member Services Department at 404-261-2590 (TTY: 711).

Your Plan provider submits the request for the services above with supporting documentation. You should call your Plan provider's office if you have not been notified of the outcome of the review within 5 working days. If your request is not approved, you have the right to ask us in writing to reconsider our initial decision (see Section 8, *The disputed claims process*).

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 or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 404-261-2590 (locally) or 888-865-5813 (long distance) (TTY: 711). You may also call OPM's FEHB 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 404-261-2590 (locally) or 888-865-5813 (long distance) (TTY: 711). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

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

Emergency services do not require preauthorization. However, if you are admitted to a 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 preauthorization 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**

Emergency services do not require preauthorization. However, if you are admitted to a 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 preauthorization from us for post-stabilization care you receive from non-Plan providers.

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

What happens when you do not follow the precertification rules

You must receive your health services at Plan facilities, except if you have an emergency, authorized referral, or out-of-area urgent care. Your primary care provider will provide most of your healthcare or give you a referral to see a specialist. If you do not obtain a referral from us for services or items that require a referral, 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 your claim is in reference to a contraceptive, call 404-261-2590 (locally in the metropolitan Atlanta area) or 888-865-5813 (long distance) (TTY: 711).

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 healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply.

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your Cost for Covered Services

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

Cost-sharing

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

Copayments

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

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

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

- Under the High Option, you pay a $15 copayment when you receive diagnostic and treatment services from a primary care provider and a $30 copayment when you receive these services from a specialty care provider.
- Under the Standard Option, you pay a $20 copayment when you receive diagnostic and treatment services from a primary care provider and a $40 copayment when you receive these services from a specialty care provider.
- Under Prosper, you pay a $20 copayment when you receive diagnostic and treatment services from a primary care provider and a $40 copayment when you receive these services from a specialty care provider.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Cost-sharing does not accrue toward the deductible. Certain other benefits, such as infertility, also do not accrue to the deductible.

- The High and Standard Option do not have a deductible.
- The calendar year deductible for Prosper is $250 per person. Under a Self Plus One or Self and family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $500 under Prosper.

Any payment you make toward the deductible for services you receive during the last three months of a calendar year will apply toward the deductible for the next calendar year.

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

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

Coinsurance

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

Example: In our High Option, Standard Option and Prosper, you pay 50% of our allowance for infertility services and 20% of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum

After your cost-sharing total is $4,000 per person up to $8,000 per family enrollment (High Option), $5,000 per person up to $10,000 per family enrollment (Standard Option) or $6,500 per person up to $13,000 per family enrollment (Prosper) in any calendar year, you do not have to pay any more for certain covered services. This includes any services required by group health plans to count toward the catastrophic protection out-of-pocket maximum by federal healthcare reform legislation (the Affordable Care Act and implementing regulations).

Example: Your plan has a $4,000 per person up to $8,000 per family maximum out-of-pocket limit. If you or one of your covered family members has out-of-pocket qualified medical expenses of $4,000 in a calendar year, any cost-sharing for qualified medical expenses for that individual will be covered fully by your health plan for the remainder of the calendar year. With a family enrollment, the out-of-pocket maximum will be satisfied once two or more family members have out-of-pocket qualified medical expenses of $8,000 in a calendar year, and any cost–sharing for qualified medical expenses for all enrolled family members will be covered fully by your health plan for the reminder of the calendar year.

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

- Chiropractic services
- Dental services
- Health education services
- Hearing aids
- Infertility services
- Travel benefit
- Payments for services under the Student Out-of-Area Coverage

Be sure to keep accurate records and receipts of your cost-sharing, 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 prior 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 prior 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 prior 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 prior 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 prior 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.

Important notice about surprise billing - know your rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by non-Plan providers with respect to patient visits to Plan health care facilities, or for
- air ambulance services furnished by non-Plan providers of air ambulance

Balance billing happens when you receive a bill from the non-Plan provider, facility, or air ambulance service for the difference between the non-Plan provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

In addition, your health plan complies with the surprise billing laws of Georgia and OCGA 33-20E-8.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.kp.org/feds or contact the health plan at 800-464-4000.

The Federal Flexible Spending Account Program – FSAFEDS

HealthCare FSA (HCFSA) - Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **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 at which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a member FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse you eligible out-of-pocket expense based on the claim information it receives from your plan.

Section 5. High Option, Standard Option and Prosper Benefits

See page 14 for how our benefits changed this year. Pages 100, 101, and 102 for a benefit summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High Option, Standard Option and Prosper Benefits Overview

This Plan offers a High Option, Standard Option and Prosper. These 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 Option, Standard Option and Prosper Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High Option, Standard Option and Prosper's benefits, contact us at 404-261-2590 (TTY: 711) or on our website at www.kp.org/feds.

Since 1985, Kaiser Permanente of Georgia has offered quality integrated healthcare to the communities we serve. As part of our continued commitment to keep pace with your healthcare needs, we have enhanced our care management programs to include “Whole Person” health coaching. Members can now enjoy one-on-one health coaching, in addition to having access to the Southeast Permanente Medical Group, Inc. and affiliated private practice physicians.

Our delivery system offers convenient, comprehensive care all under one roof. You can come to many of our medical facilities and see a primary care provider, pediatrician, OB/GYN, and other specialists, 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 and 7 days a week, to schedule appointments, send secure messages to your provider, refill prescriptions, research medical conditions and view your medical information on line.

This Plan offers three options: the High Option, Standard Option and Prosper. These options are designed to include preventive and acute care services provided by our Plan providers. The options offer different levels of benefits and services for you to choose between to best fit your healthcare needs.

Each option offers unique features.

High Option

Our High Option provides the most comprehensive benefits. There is no calendar year deductible. You pay a copayment for most covered services. You get high quality, personalized care with The Southeast Permanente Medical Group, Inc. and affiliated private practice physicians on the High Option, Standard Option and Prosper.

Standard Option

With the Standard Option there is no calendar year deductible and your cost-sharing may be higher than for the High Option; however, your bi-weekly premium contribution is lower.

Prosper

With Prosper, there is a calendar year deductible of $250 per person ($500 per Self Plus One or Self and Family) and your cost-sharing may be higher than for the Standard Option; however, your bi-weekly premium contribution is lower.

Additional Benefits – Dental

Please note, with either the High or Standard Option you automatically receive preventive dental plan benefits as described in Section 5(g), administered by Delta Dental, Inc. For more extensive dental benefits you may also choose the voluntary comprehensive dental benefits through the DeltaCare USA Dental Program, administered by Delta Dental Insurance Company as described in Section 5, Non-FEHB benefits available to Plan members.

Please review this brochure carefully to learn which of our Kaiser Foundation Health Plan of Georgia FEHB options is best for you. If you would like more information about our benefits please contact us at 404-261-2590 (TTY: 711) or visit our website at www.kp.org/feds.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copayment applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- High and Standard Option do not have a calendar year deductible.
- The calendar year deductible for Prosper is $250 per person ($500 per family). The calendar year deductible applies to some of the benefits in this Section. We added "after the deductible" when the calendar year deductible applies.
- Be sure to read Section 4, *Your Cost for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Different copayments apply for primary care visits and specialty care visits in the High Option, Standard Option and Prosper. Please refer to Section 10, Definitions, to learn more about when your primary and specialty care copayments will apply.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay		
Note: Prosper calendar year deductible applies to some benefits in this Section. We say "after the deductible" when the calendar year deductible applies.			
Diagnostic and treatment services	**High Option**	**Standard Option**	**Prosper**
Professional services of physicians and other healthcare professionals • In physician's office • Office medical consultations • Second surgical opinion	$15 per primary care office visit (nothing for children through age 17) $30 per specialty care office visit	$20 per primary care office visit (nothing for children through age 17) $40 per specialty care office visit	$20 per primary care office visit $40 per specialty care office visit
Professional services of physicians and other healthcare professionals • To receive injections • Advanced care planning	$15 per primary care office visit $30 per specialty care office visit	$20 per primary care office visit $40 per specialty care office visit	$20 per primary care office visit $40 per specialty care office visit
• During a hospital stay • In a skilled nursing facility • At home	Nothing	Nothing	Nothing

Benefit Description	You pay		
Telehealth services	**High Option**	**Standard Option**	**Prosper**
Professional services of physicians and other healthcare professionals delivered through telehealth, such as: • Interactive video visit • Phone visits • Email Note: Visits may be limited by provider type, location and benefit specific limitations, such as visit limits.	Nothing	Nothing	Nothing
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**	**Prosper**
Tests, such as: • Blood test • Urinalysis • Non-routine Pap test • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing	Nothing	Nothing
• CT/CAT scan • MRI • Nuclear medicine • PET scan	$30 per office visit	$100 per office visit	$100 per office visit after the deductible
Preventive care, adult	**High Option**	**Standard Option**	**Prosper**
One routine physical exam per calendar year The following preventive services are covered at the time interval recommended at each of the links below: • Immunizations such as Pneumococcal, influenza, shingles, tetanus/Tdap, and human papillomavirus (HPV). For a complete list of immunizations visit the Centers for Disease Control (CDC) website at www.cdc.gov/vaccines/schedules • Screenings such as for breast cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings visit the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations	Nothing	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Prosper**
• Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women please visit the Health and Human Services (HHS) website at www.healthcare.gov/preventive-care-women • Services such as routine prostate specific antigen (PSA) test, anemia and urinary tract infection • We cover other preventive services required by federal healthcare reform legislation (the Affordable Care Act and implementing regulations) and additional services that we include in our preventive services benefit. For a complete list of Kaiser Permanente preventive services visit our website at www.kp.org/prevention • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Nothing	Nothing	Nothing
• Routine mammogram covered	Nothing	Nothing	Nothing
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. • Medical Nutrition Therapy and Intensive Behavioral Therapy for the prevention of obesity related comorbidities as recommended under the U.S. Preventive Services Task Force (USPSTF) A and B recommendations.	Nothing	Nothing	Nothing
Notes: • You may pay cost-sharing for any procedure, injection, diagnostic service, laboratory or X- ray service that is provided in conjunction with a routine physical exam and not included in the recommended listing of services. • You should consult with your physician to determine what is appropriate for you.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered:	*All charges*	*All charges*	*All charges*

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Physical exams and immunizations required for:* - *Obtaining or continuing employment* - *Insurance or licensing* - *Attending schools, sports or camp* - *Athletic exams* - *Participating in employee programs* - *Court ordered parole or probation* - *Travel* - *Work related exposure*	*All charges*	*All charges*	*All charges*
Preventive care, child	**High Option**	**Standard Option**	**Prosper**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines visit brightfutures.aap.org/ • Immunizations such as DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations visit the Centers for Disease Control (CDC) website at www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of A and B recommended preventive care services under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • We cover other preventive services required by federal healthcare reform legislation (the Affordable Care Act and implementing regulations) and additional services that we include in our preventive services benefit. For a complete list of Kaiser Permanente preventive services visit our website at www.kp.org/prevention • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Nothing	Nothing	Nothing
Notes:	Applies to this benefit	Applies to this benefit	Applies to this benefit

Preventive care, child - continued on next page

Benefit Description	You pay		
Preventive care, child (cont.)	**High Option**	**Standard Option**	**Prosper**
• You may pay cost-sharing for any procedure, injection, diagnostic service, laboratory or X- ray service that is provided in conjunction with a routine physical exam and not included in the preventive recommended listing of services. • Hearing screenings are provided by a primary care provider 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.*	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Physical exams and immunizations required for:* - *Obtaining or continuing employment* - *Insurance or licensing* - *Attending schools, sports or camp* - *Athletic exams* - *Participating in employee programs* - *Court ordered parole or probation* - *Travel* - *Work related exposure* • *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*	*All charges*
Maternity care	**High Option**	**Standard Option**	**Prosper**
Complete maternity (obstetrical) care, such as: • Prenatal and postpartum care • Screening for gestational diabetes • Screening and counseling for prenatal and postpartum depres	Nothing	Nothing	Nothing
• Breastfeeding support, supplies, and counseling for each birth Note: We cover breastfeeding pumps and supplies under the Durable Medical Equipment (DME).	Nothing	Nothing	Nothing
• All other visits during pregnancy (such as visits to genetics counselors and perinatologists)	$30 per office visit	$40 per office visit	$40 per office visit
• Delivery	Nothing for inpatient professional delivery services	Nothing for inpatient professional delivery services	Nothing for inpatient professional delivery services
Notes:	Applies to this benefit	Applies to this benefit	Applies to this benefit

Maternity care - continued on next page

Benefit Description	You pay		
Maternity care (cont.)	**High Option**	**Standard Option**	**Prosper**
• Routine maternity care is covered after confirmation of pregnancy. • Your Plan provider does not have to obtain prior approval from us for your vaginal delivery. See Section 3, You need prior Plan approval for certain services, for prior approval guidelines. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • You pay cost-sharing for other services, including: - Diagnostic and treatment services for illness or injury received during a non-routine maternity care as described in this section - Lab, X-ray and other diagnostic tests (including ultrasounds), Durable medical equipment as described in this section - Surgical services (including circumcision of an infant if performed at the mother's discharge from the hospital) as described in Section 5(b). Outpatient hospital or ambulatory surgical center - Hospitalization (including room and board and delivery) as described in Section 5(c). Inpatient hospital	Applies to this benefit	Applies to this benefit	Applies to this benefit

Benefit Description	You pay		
Family planning	**High Option**	**Standard Option**	**Prosper**
A range of voluntary family planning services, limited to: • Female voluntary sterilization • Surgically implanted contraceptive drugs • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Family planning counseling • Contraceptives counseling • Male family planning services are covered in Primary and Specialty office visits. See Section 5(a), *Diagnostic and treatment services*. Note: See Section 5(b), *Surgical and Anesthesia Services* for coverage of voluntary sterilization for males and females and section 5 (f), *Prescription Drug Benefits* for oral contraceptives and devices such as diaphragms	Nothing	Nothing	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**	**Prosper**
Diagnosis of infertility	$30 per office visit	$40 per office visit	$40 per office visit
Treatment of infertility, such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Semen analysis • Hysterosalpingogram • Hormone evaluation	50% of our allowance	50% of our allowance	50% of our allowance

Infertility services - continued on next page

Benefit Description	You pay		
Infertility services (cont.)	**High Option**	**Standard Option**	**Prosper**
Standard fertility preservation for iatrogenic infertility • Retrieval of sperm and eggs • Cryopreservation storage for preserved specimen for 1 year after a covered preservation procedure or when your enrollment ends, whichever is sooner Notes: • See Section 5(f), *Prescription drug benefits*, for coverage of fertility drugs. • Infertility is the inability of an individual to conceive or produce conception during a period of 1 year if the female is age 35 or younger, or during a period of 6 months if the female is over the age of 35, or having a medical or other demonstrated condition that is recognized by a Plan physician as a cause of infertility. See Section 3, *You need prior Plan approval for certain services*, for more information. • A Plan physician will determine the appropriate treatment and number of attempts for infertility treatment.	50% of our allowance	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* (IVF) - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Ovum transplants* • *Infertility services when either member of the family has been voluntarily surgically sterilized.* • *Services to reverse voluntary, surgically induced infertility* • *Any charges associated with donor eggs, donor sperm, or donor embryos* • *Any charges associated with cryopreservation or with thawing and storage of frozen sperm, eggs, and embryos, unless listed as covered above for iatrogenic infertility*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Allergy care	**High Option**	**Standard Option**	**Prosper**
• Testing and treatment	$30 per office visit	$40 per office visit	$40 per office visit
• Injections	$15 per primary care office visit $30 per specialty care office visit	$20 per primary care office visit $40 per specialty care office visit	$20 per primary care office visit $40 per specialty care office visit
• Serum	Nothing	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**	**Prosper**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants in Section 5(b).	$30 per office visit	$40 per office visit	$40 per office visit
• Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/condition is provided for up to 12 weeks or 36 visits, whichever comes first • Growth hormone therapy (GHT) • Ultraviolet light treatments Note: Growth hormone requires our prior approval and is covered under the prescription drug benefit. See Section 3, *You need prior Plan approval for certain services* and Section 5 (f), *Prescription drug benefits*.	$30 per office visit	$40 per office visit	$40 per office visit
• Applied Behavioral Analysis (ABA) for children through age 20 for the treatment of autism spectrum disorder Note: Applied Behavioral Analysis treatment requires prior authorization. See section 3. *You need prior plan approval for certain services*, for more information.	Nothing	Nothing	Nothing
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Dialysis - hemodialysis and peritoneal dialysis	Nothing at home $30 per office visit	Nothing at home $40 per office visit	Nothing at home $40 per office visit

Benefit Description	You pay		
Physical and occupational therapies	**High Option**	**Standard Option**	**Prosper**
• Up to 20 visits combined per condition per calendar year for: - Physical habilitative and rehabilitative therapy by qualified physical therapists to attain or restore bodily function when you have a total or partial loss of bodily function due to illness or injury - Occupational habilitative and rehabilitative therapy by occupational therapists to assist you in attaining or 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.	$30 per visit	$40 per visit	$40 per visit
Comprehensive outpatient rehabilitation facility services	Nothing	$40 per visit	$40 per visit
Not covered: • *Long-term therapy* • *Exercise programs* • *Maintenance therapy* • *Cognitive rehabilitation programs, except in cases of traumatic brain injury* • *Vocational rehabilitation programs* • *Therapies done primarily for educational purposes* • *Services provided by local, state and federal government agencies, including schools*	*All charges*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**	**Prosper**
Habilitative and rehabilitative services for up to 20 visits per condition per calendar year	$30 per visit	$40 per visit	$40 per visit
Not covered: • *Long-term speech therapy* • *Therapies done primarily for educational purposes* • *Therapy for tongue thrust in the absence of swallowing problems* • *Training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation* • *Voice therapy for occupation or performing arts* • *Services provided by local, state, and federal government agencies including schools*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**	**Prosper**
For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., audiologist or other provider in a physician's office Note: For coverage of hearing screenings, see Section 5(a). Preventive care adult and Preventive care children and for any other hearing testing, see Section 5(a) Diagnostic and treatment services.	$15 per primary care office visit $30 per specialty care office visit	$15 per primary care office visit $30 per specialty care office visit	$15 per primary care office visit $30 per specialty care office visit
Hearing aids for children through age 18, including testing and examinations Notes: For coverage of: • Audible prescription reading and speech generating devices, see Section 5(a), Durable medical equipment.	*All charges* in excess of $3,000 for each hearing impaired ear every 48 months	*All charges* in excess of $3,000 for each hearing impaired ear every 48 months	*All charges* in excess of $3,000 for each hearing impaired ear every 48 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 19 and over* • *Batteries for hearing aids and replacement of lost hearing aids*	*All charges*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**	**Prosper**
• Diagnosis and treatment of diseases of the eye • Routine eye exam with a Plan optometrist to determine the need for vision correction and provide a prescription for eyeglasses	$30 per office visit	$40 per office visit	$40 per office visit
Not covered: • *Eyeglasses and frames* • *Contact lenses, examinations for contact lenses or the fitting of contact lenses* • *Eye surgery solely for the purpose of correcting refractive defects of the eye* • *Vision therapy, including orthoptics, visual training and eye exercises* • *Low vision aids*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Foot care	**High Option**	**Standard Option**	**Prosper**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$15 per primary care office visit $30 per specialty care office visit	$20 per primary care office visit $40 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*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**	**Prosper**
External prosthetic and orthotic devices, such as: • Artificial limbs and eyes • Prosthetic sleeve or sock • 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 • Therapeutic shoes required for conditions associated with diabetes • Braces • Scoliosis braces	20% of our allowance	20% of our allowance	20% of our allowance after the deductible
Internal prosthetic devices, such as: • Artificial joints • Pacemakers • Cochlear implants • Surgically implanted breast implants following mastectomy • Intraocular implant following cataract removal Note: See 5(b), Surgery benefits, for coverage of the surgery to insert the device and Section 5 (c), Hospital benefits, for inpatient hospital benefits.	Nothing	Nothing	Nothing
Notes:	Applies to this benefit	Applies to this benefit	Applies to this benefit

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay		
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**	**Prosper**
• Orthopedic and prosthetic equipment or services must be prescribed by a Plan physician; obtained through sources designated by the Plan; consistent with Medicare guidelines; and primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury. • We cover only those standard items that are adequate to meet the medical needs of the member. • For coverage of hearing aids, see Section 5 (a), Hearing services.	Applies to this benefit	Applies to this benefit	Applies to this benefit
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* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Dental prostheses, devices, and appliances, except oral devices or appliance used to reduce upper airway collapsibility* • *Repairs, adjustments, or replacements due to misuse, theft or loss*	*All charges*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**	**Prosper**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen and oxygen dispensing equipment • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Speech generating devices • Blood glucose monitors • Insulin pumps • Infant apnea monitors	20% of our allowance	20% of our allowance	20% of our allowance after the deductible

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay		
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**	**Prosper**
• One breastfeeding pump per delivery, including any equipment and supplies that are required for pump functionality.	20% of our allowance for hospital-grade pump Nothing for retail-grade pump and breastfeeding supplies	20% of our allowance for hospital-grade pump Nothing for retail-grade pump and breastfeeding supplies	20% of our allowance after the deductible for hospital-grade pump Nothing for retail-grade pump and breastfeeding supplies
• Home phototherapy equipment for the treatment of psoriasis and atopic dermatitis • Enteral and parenteral elemental dietary formulas and amino acid modified product for the treatment of inborn errors of metabolism	Nothing	Nothing	Nothing
Notes: • We only provide DME in the Plan's service area. • 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. • Durable medical equipment (DME) is equipment that is prescribed 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.	Applies to this benefit	Applies to this benefit	Applies to this benefit

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay		
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**	**Prosper**
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* • *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* • *Disposable supplies* • *Replacement batteries* • *Repairs, adjustments, or replacements due to misuse, theft or loss*	*All charges*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**	**Prosper**
• Home healthcare 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.), home health aide, physical or occupational therapist, and speech and language pathologist. • Services include oxygen therapy, intravenous therapy and medications. Notes: • We only provide these services in the Plan's service areas. • These services are covered only if you are homebound and a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home.	Nothing	Nothing	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family*	*All charges*	*All charges*	*All charges*

Home health services - continued on next page

Benefit Description	You pay		
Home health services (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Custodial care* • *Private duty nursing* • *Personal care and hygiene items* • *Care that a Plan provider determines may be appropriately provided in a Plan facility, hospital, skilled nursing facility or other facility we designate and we provide*	*All charges*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**	**Prosper**
Up to 20 visits per calendar year, limited to: • Diagnosis and treatment of neuromusculoskeletal disorders • Laboratory tests, pathology and plain film X-rays associated with diagnosis and treatment (not to exceed 4 views) • Adjunctive therapies such as ultrasound, electrical muscle stimulation, and vibratory therapy, not to exceed 2 per visit Notes: • You may only self-refer to a participating chiropractor. The participating chiropractor must provide, arrange or prescribe your care. • For a list of participating chiropractors, contact our Member Services Department at 404-261-2590 (TTY: 711).	$30 per office visit	$40 per office visit	$40 per office visit
Not covered: • *Hypnotherapy, behavior training, sleep therapy and weight programs* • *Thermography* • *Any radiological exam other than plain film studies such as magnetic resonance imaging, CT scans, bone scans, nuclear radiology* • *Treatment for non-neuromusculoskeletal disorders* • *Chiropractic appliances, except as covered in Section 5(a), Durable medical equipment and Prosthetics and orthotic devices*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Alternative treatments	**High Option**	**Standard Option**	**Prosper**
Not covered, including acupuncture	*All charges*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**	**Prosper**
Health education classes, including: • Stress reduction • Chronic conditions, such as diabetes and asthma	$15 per office visit	$20 per office visit	$20 per office visit
• Tobacco cessation programs, including individual, group and phone counseling, prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco cessation.	Nothing	Nothing	Nothing
• General health education not addressed to a specific condition, as well as Lamaze classes and weight control	Charges vary	Charges vary	Charges vary
• Childhood obesity Screening programs and treatment interventions	Nothing - $10/ program	Nothing - $10/ program	Nothing - $10/ program
Notes: • Please call Member Services at 404-261-2590 for information on cost and classes near you. • See Section 5(f), Prescription drug benefits, for important information about coverage of tobacco cessation and other drugs.	Applies to this benefit	Applies to this benefit	Applies to this benefit

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. Consult with your physician to determine what is appropriate for you. Services may be covered provided that established Plan physicians' criteria are met.
- The High and Standard Option do not have a calendar year deductible.
- The calendar year deductible for Prosper is $250 per person ($500 per family). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" when the calendar year deductible applies.
- 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 cost-sharing listed below applies to services billed by a physician or other healthcare professional for your surgical care. See Section 5(a) for cost-sharing you pay for services performed during an office visit or 5(c) cost-sharing you pay for services in an inpatient hospital, outpatient hospital or ambulatory surgical center facility.
- **YOUR PROVIDER MUST GET PRIOR APPROVAL FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay		
Note: Prosper calendar year deductible applies to some benefits in this Section. We say "after the deductible" when the calendar year deductible applies.			
Surgical procedures	**High Option**	**Standard Option**	**Prosper**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery)	Nothing	Nothing	Nothing
• Surgical treatment of severe obesity (bariatric surgery). Notes:	Nothing	Nothing	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay		
Surgical procedures (cont.)	**High Option**	**Standard Option**	**Prosper**
• Visit kp.org/feds to get a list of criteria you must meet to qualify for bariatric surgery. This program may refer you to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including: - nutritional, - psychological, - medical; and - social readiness for surgery. • Final approval for surgical treatment will be required from The Southeast Permanente Medical Group's designated physician. See Section 3, *You need prior Plan approval for certain services*, for more information.	Nothing	Nothing	Nothing
• Insertion of internal prosthetic devices. See 5 (a), *Orthopedic and prosthetic devices,* for device coverage information • Male voluntary sterilization (e.g., vasectomy) • Treatment of burns Notes: • Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing	Nothing	Nothing
• Female voluntary sterilization, including anesthesia and confirmation testing following tubal occlusion • Surgically implanted time-released contraceptives and insertion of intrauterine devices (IUDs)	Nothing	Nothing	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay		
Surgical procedures (cont.)	**High Option**	**Standard Option**	**Prosper**
Notes: • We cover the cost of these surgically implanted time-release contraceptive drugs and intrauterine devices under the prescription drug benefit (see Section 5(f)).	Nothing	Nothing	Nothing
Not covered: • Reversal of voluntary sterilization • Services for the promotion, prevention, or other treatment of hair loss or hair growth • Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form	*All charges*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**	**Prosper**
• 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; and webbed fingers and toes. Note: We cover orthodontia services as a result of cleft lip and/or cleft palate. • Surgery for treatment of a form of congenital hemangioma known as port wine stains on the face • 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*)	Nothing	Nothing	Nothing

Reconstructive surgery - continued on next page

Benefit Description	You pay		
Reconstructive surgery (cont.)	**High Option**	**Standard Option**	**Prosper**
Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • Gender Affirming Surgery	Nothing	Nothing	Nothing
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*	*All charges*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**	**Prosper**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • 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, except extraction of the teeth to prepare the jaw for radiation treatment of neoplastic disease.	Nothing	Nothing	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Shortening of the mandible or maxillae for cosmetic purposes* • *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*	*All charges*

Benefit Description	You pay		
Organ/tissue transplants	**High Option**	**Standard Option**	**Prosper**
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 preauthorization procedures. Solid organ tissue transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart-lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: Single/bilateral/lobar • Pancreas	Nothing	Nothing	Nothing
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to Section 3 for prior authorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing	Nothing	Nothing
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous [myeloid]) leukemia - Hodgkin's lymphoma (relapsed) - Non-Hodgkin's lymphoma (relapsed) - Advanced neuroblastoma	Nothing	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell transplant (HSCT) - Hemoglobinopathies (e.g., thalassemias, Sickle cell disease) - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow Failure and Related Disorders (i.e., Fanconi's, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe Aplastic Anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Hodgkin's lymphoma (relapsed) - Non-Hodgkin's lymphoma (relapsed) - Amyloidosis - Ewing sarcoma - Hematopoietic stem cell transplant (HSCT) - Immune deficiency diseases other than SCID (e.g., Wiskott-Aldrich syndrome, Kostmann's Syndrome, Leukocyte Adhesion Deficiencies) not amenable to more conservative treatments - Medulloblastoma - Multiple myeloma - Neuroblastoma - Phagocytic/Hemophagocytic deficiency diseases - Pineoblastoma	Nothing	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Waldenstrom's macroglobulin •	Nothing	Nothing	Nothing
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. • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Beta Thalassemia Major • Breast cancer • Childhood rhabdomyosarcoma • Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) • Chronic lymphocytic leukemia • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) relapsed/refractory disease • Chronic myelogenous leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial ovarian cancer • High-grade (Aggressive) non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) • High-risk Ewing sarcoma • High risk childhood kidney cancers • Hodgkin's lymphoma • Multiple myeloma • Multiple sclerosis • Myeloproliferative Disorders • Myelodysplasia/Myelodysplastic Syndromes • Non-Hodgkin's lymphoma • Sarcomas • Sickle Cell • Systemic lupus erythematosus • Systemic sclerosis	Nothing	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
• Scleroderma • Scleroderma-SSc (severe, progressive)	Nothing	Nothing	Nothing
Mini-transplants performed in a Clinical Trial Setting (non-myeloblative, reduced intensity conditioning). • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow Failure and Related Disorders (i. e. Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing	Nothing	Nothing
Notes: • We cover related medical and hospital expenses of the donor when we cover the recipient.	Applies to this benefit	Applies to this benefit	Applies to this benefit

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
• 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.	Applies to this benefit	Applies to this benefit	Applies to this benefit
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*	*All charges*
Anesthesia	**High Option**	**Standard Option**	**Prosper**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	Nothing	Nothing

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The High and Standard Option do not have a calendar year deductible.
- The calendar year deductible for Prosper is $250 per person ($500 per family). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" when the calendar year deductible applies.
- Be sure to read Section 4, *Your cost for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PROVIDER MUST GET PRIOR APPROVAL FOR HOSPITAL STAYS**. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay		
Note: Prosper calendar year deductible applies to some benefits in this Section. We say "after the deductible" when the calendar year deductible applies.			
Inpatient hospital	**High Option**	**Standard Option**	**Prosper**
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.	$500 per admission $250 per admission maternity care	$750 per admission Nothing per admission for maternity care	$750 per admission after the deductible $750 per admission after the deductible for maternity care
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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	Nothing	Nothing	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay		
Inpatient hospital (cont.)	**High Option**	**Standard Option**	**Prosper**
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	Nothing
• Medical supplies and equipment, including oxygen, and any covered items billed by a hospital for use at home	According to the benefit of the specific item you take home (i.e., hospital bed, pharmacy items, etc.)	According to the benefit of the specific item you take home (i.e., hospital bed, pharmacy items, etc.)	According to the benefit of the specific item you take home (i.e., hospital bed, pharmacy items, etc.)
Not covered: • *Custodial care and care in an intermediate care facility* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, and guest meals and beds* • *Private nursing care, except when medically necessary* • *Inpatient dental procedures* • *Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient*	*All charges*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**	**Prosper**
• Operating, recovery, and other treatment rooms • Observation care • Prescribed drugs and medications • Lab, X-ray, and other diagnostic tests • Blood and blood products • Pre-surgical testing • Dressings, casts, and sterile trays • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service Notes: • For observation care associated with an emergency room visit, see Section 5(d) Emergency services/Accidents.	$150 per visit	$200 per visit	$250 per visit after the deductible

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay		
Outpatient hospital or ambulatory surgical center (cont.)	**High Option**	**Standard Option**	**Prosper**
• We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. See Section 5(g) for dental information.	$150 per visit	$200 per visit	$250 per visit after the deductible
Not covered: • Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient	All charges	All charges	All charges
Skilled nursing care facility benefits	**High Option**	**Standard Option**	**Prosper**
Up to 100 days per calendar year when you need full-time nursing care. All necessary services are covered, including: • Room and board • General nursing care • Medical social services • Prescribed drugs, biologicals, supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility	Nothing	Nothing	Nothing
Not covered: • *Custodial care and care in an intermediate care facility* • *Personal comfort items, such as phone, television, barber services, and guest meals and beds*	*All charges*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**	**Prosper**
Supportive and palliative care for a terminally ill member: • You must reside in the service area • Services are provided in the home, when a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home. 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 six months or less.	Nothing	Nothing	Nothing

Hospice care - continued on next page

Benefit Description	You pay		
Hospice care (cont.)	**High Option**	**Standard Option**	**Prosper**
Not covered: • *Independent nursing (private duty nursing)* • *Homemaker services*	*All charges*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**	**Prosper**
• Local licensed ambulance service when medically necessary Note: See Section 5(d) for emergency services	$100 per trip	$125 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*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The High and Standard Option do not have a calendar year deductible.
- The calendar year deductible for Prosper is $250 per person ($500 per family). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" when the calendar year deductible applies.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

If you have a medical emergency, dial 911 or go to the nearest emergency room.

Emergencies within our service area:

Emergency care is provided at Plan hospitals 24 hours a day, seven days a week. The location and phone number of your nearest Plan hospital may be found in your FEHBP Facility Guide.

If you think you have a medical emergency condition and you cannot safely go to a Plan hospital, call 911 or go to the nearest hospital. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 24 hours, unless it was not reasonably possible to do so.

If you need to be hospitalized, the Plan must be notified within 24 hours or as soon as reasonably possible. If you are hospitalized in non-Plan facilities and Plan physicians believe care can be better provided in a Plan hospital, we will transfer you when medically feasible, with any ambulance charges covered in full.

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

To request preauthorization for post-stabilization care from a non-Plan provider, you must call us at (404) 365-0966 (locally) or 800 611-1811 (long distance or the notification phone number on your Kaiser Permanente ID card) before you receive the care if it is reasonably possible to do so (otherwise call us as soon as reasonably possible). After we are notified, we will discuss your condition with the non-Plan provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a Plan provider, we will authorize your care from the non-Plan provider only if we cannot arrange to have a Plan provider (or other designated provider) provide the care. If we decide to have a Plan hospital, skilled nursing facility, or designated non-Plan provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

We understand that extraordinary circumstances can delay your ability to call us to request preauthorization for post-stabilization care from a non–Plan provider, for example, if a young child is without a parent or guardian present, or you are unconscious. In these cases, you must call us as soon as reasonably possible. Please keep in mind that anyone can call us for you. We will not pay for any services you receive from non–Plan providers after your emergency medical condition is stabilized unless you obtain preauthorization, so if you don't call as soon as reasonably possible, you will be financially responsible for this post-stabilization care.

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 phone numbers.

Emergencies outside our service area:

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

If you need to be hospitalized, the Plan must be notified within 24 hours or as soon as reasonably possible. If a Plan physician believes care can be better provided in a Plan hospital, then we will transfer you when medically feasible, with any ambulance charges covered in full.

When you are sick or injured, you may have an urgent care need. An urgent care need is one that requires prompt medical attention, but is not a medical emergency. If you think you may need urgent care, call the appropriate appointment or advice nurse number at a Plan facility. Please refer to the Guidebook for advice nurse and Plan facility phone 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 phone book under Kaiser Permanente. These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling the Member Services Department in the Atlanta area at 404-261-2590, or from other areas at 888-865-5813 (TTY: 711).

Benefit Description	You pay		
Emergency within our service area	**High Option**	**Standard Option**	**Prosper**
• Urgent care at a Plan urgent care center	$30 per office visit	$40 per office visit	$40 per visit
• Emergency care at an urgent care center not designated by the Plan • Emergency care as an outpatient at a hospital, including physicians' services • Urgent care at a Plan emergency room Notes: • If you receive emergency care and then are transferred to an observation bed or status, you pay the emergency services cost-sharing. If you are admitted as an inpatient, we will waive your emergency room copayment and you will pay your cost-sharing related to your inpatient hospital stay.	$200 per visit	$200 per visit	$250 per visit

Emergency within our service area - continued on next page

Benefit Description	You pay		
Emergency within our service area (cont.)	**High Option**	**Standard Option**	**Prosper**
Not covered: • *Elective care or non-emergency care* • *Urgent care at a non-Plan urgent care center or emergency*	*All charges*	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**	**Prosper**
• Urgent care at an urgent care center	$30 per visit	$40 per visit	$40 per visit
• Emergency care at an urgent care center not designated by the Plan • Emergency care as an outpatient at a hospital, including physicians' services • Urgent care at an emergency room Notes: • If you receive emergency care and then are transferred to an observation bed or status, you pay the emergency services cost-sharing. If you are admitted as an inpatient, we will waive your emergency room copayment and you will pay your cost-sharing related to your inpatient hospital stay. • See Section 5(h) for travel benefit coverage of continuing or follow-up care.	$200 per visit	$200 per visit	$250 per visit
Not covered: • *Elective care or non-emergency care* • *Follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**	**Prosper**
Licensed ambulance service when medically necessary. Notes: • See Section 5(c) for non-emergency service. • Trip means any time an ambulance is summoned on your behalf.	$100 per trip	$125 per trip	$150 per trip

Ambulance - continued on next page

Benefit Description	You pay		
Ambulance (cont.)	**High Option**	**Standard Option**	**Prosper**
Not covered: • *Trips we determine are not medically necessary* • *Transportation by car, taxi, bus, gurney van, wheelchair van, minivan and any other type of transportation, even if it is the only way to travel to a provider or facility*	*All charges*	*All charges*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder 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.
- Plan physicians must provide or arrange your care.
- The High and Standard Option do not have a calendar year deductible.
- The calendar year deductible for Prosper is $250 per person ($500 per family). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" when the calendar year deductible applies.
- 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.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay		
Note: The calendar year deductible applies to some benefits under Prosper in this Section. We say "after the deductible" when the calendar year deductible applies.			
Professional services	**High Option**	**Standard Option**	**Prosper**
We cover professional services recommended by a Plan mental health or substance use disorder treatment provider that are covered services, drugs, and supplies described in this brochure. Notes: • We cover the services only when we determine the care is clinically appropriate to treat your condition.	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.	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: - Crisis intervention and stabilization for acute episodes - Medication evaluation and management (pharmacotherapy)	$15 per individual therapy office visit $15 per individual therapy office visit (Nothing for children through age 17)	$20 per individual therapy office visit $20 per individual therapy office visit (Nothing for children through age 17)	$20 per individual therapy office visit $20 per individual therapy office visit
- Treatment and counseling (including group and individual therapy visits)	$7 per group therapy office visit (Nothing for children through age 17)	$10 per group therapy office visit (Nothing for children through age 17)	$10 per group therapy office visit
• Diagnosis and treatment of substance use disorders. Services include:	$15 per individual therapy office visit	$20 per individual therapy office visit	$20 per individual therapy office visit

Professional services - continued on next page

Benefit Description	You pay		
Professional services (cont.)	**High Option**	**Standard Option**	**Prosper**
- Detoxification (medical management of withdrawal from the substance) - Treatment and counseling (including individual and group therapy visits) - Rehabilitative care	$15 per individual therapy office visit $7 per group therapy office visit (Nothing for children through age 17)	$20 per individual therapy office visit $10 per group therapy office visit (Nothing for children through age 17)	$20 per individual therapy office visit $10 per group therapy office visit
• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Electroconvulsive therapy	$15 per office visit (Nothing for children through age 17)	$20 per office visit (Nothing for children through age 17)	$20 per office visit
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) Lab, X-ray and other diagnostic tests.	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) Lab, X-ray and other diagnostic tests.	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) Lab, X-ray and other diagnostic tests.
Notes: • You may see a Plan mental health or substance use provider for these services without a referral from your primary care provider. See Section 3, How you get care, for information about services requiring our prior approval. • Your Plan mental health or substance use 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. • See Section 5(a), Treatment therapy for coverage of Applied Behavior Analysis (ABA).	Applies to this benefit	Applies to this benefit	Applies to this benefit
Diagnostics	**High Option**	**Standard Option**	**Prosper**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) Lab, X-ray and other diagnostic tests.	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) Lab, X-ray and other diagnostic tests.	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) Lab, X-ray and other diagnostic tests.

Benefit Description	You pay		
Inpatient hospital or other covered facility	**High Option**	**Standard Option**	**Prosper**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services Note: All inpatient admissions require approval by a Plan mental health or substance use physician.	$500 per admission	$750 per admission	$750 per admission after the deductible
Outpatient hospital or other covered facility	**High Option**	**Standard Option**	**Prosper**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, facility based intensive outpatient treatment Note: All hospital alternative services treatment programs require approval by a Plan mental health or substance use physician.	$150 per visit	$200 per visit	$250 per visit after the deductible
Not covered	**High Option**	**Standard Option**	**Prosper**
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Intelligence, IQ, aptitude ability, learning disorders or interest testing not necessary to determine the appropriate treatment of a psychiatric condition* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* • *Services that are custodial in nature* • *Marital, family or educational services* • *Services rendered or billed by a school or a member of its staff* • *Services provided under a federal, state or local government program* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms*	*All charges*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on page 60.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year pharmacy deductible.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed Plan provider or licensed dentist must prescribe your medication. We cover prescriptions written by a non-Plan provider or filled at a non-Plan pharmacy only for emergencies or out-of-area urgent care (see Section 5(d), *Emergency services/accidents)*, or as stated in this section.
- **Where you can obtain them.** You may obtain a first fill of your prescription at a Plan medical office pharmacy or a Plan participating community pharmacy, or by the Plan mail order program for certain maintenance medications, as specified below. All refills of your prescription must be obtained at a Plan medical office pharmacy or through the Plan mail order program only. You can order prescriptions from Kaiser Permanente's network mail-order pharmacy service in the following ways.
  - Call 770-434-2008, option 1;
  - Call 888-662-4579;
  - Go to our website at www.kp.org/rxrefill and follow the instructions for refilling prescriptions (the Web can only be used for prescriptions that were originally filled at pharmacies located in Kaiser Permanente Medical Centers).
  - Fill out and send in your request by using one of our mail-order pharmacy envelopes. You can order a supply by calling our Member Services Department at 404-261-2590 (TTY: 711). When you use this method of ordering, you can pay by check or credit card.

Allow at least 5 - 7 business days for the prescription to be filled and delivered to you by mail.

Plan members called to active military duty (or members in time of national emergency), who need to obtain prescribed medications, should call a Plan pharmacy.

- **We use a managed 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 describe any additional coverage requirements and limits in our FEHB formulary. These may include step therapy, prior authorization, quantity limits, drugs that can only be obtained at certain specialty pharmacies, or other restrictions and limits described in our formulary. 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 believes that a non-formulary drug best treats your medical condition; a formulary drug has been ineffective in the treatment of your medical condition; or a formulary drug causes or is reasonably expected to cause a harmful reaction. If you request the non-formulary drug when your Plan provider has prescribed a formulary drug, 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. For more information on our prescription drug FEHB formulary, visit kp.org/formulary or call our Member Services Department at 404-261-2590.

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

- **Tier 1: Preferred generic drugs.** Generic drugs are produced and sold under their generic names after the patent of the brand-name drug expires. Although the price is usually lower, the quality of generic drugs is the same as brand-name drugs. Generic drugs are also just as effective as brand-name drugs. The Food and Drug Administration (FDA) requires that a generic drug contain the same active drug ingredient in the same amount as the brand-name drug.
- **Tier 2: Non-preferred generic drugs.** Non-preferred generic drugs are not listed on our drug formulary.
- **Tier 3: Preferred brand-name drugs.** Brand-name drugs are produced and sold under the original manufacturer's brand name. Preferred brand-name drugs are listed on our drug formulary.
- **Tier 4: Non-preferred brand-name drugs.** Non-preferred brand-name drugs are not listed on our drug formulary.
- **Tier 5: Specialty drugs.** Specialty drugs are high-cost drugs that are on our specialty drug list.

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

- **These are the dispensing limitations.** We provide up to the lesser of a 30-day supply of prescribed covered drugs and certain supplies dispensed in a Plan pharmacy at one copayment or up to a 90-day supply for most drugs when dispensed in a Plan pharmacy for three copayments or through our mail order program for two copayments. We cover episodic drugs prescribed to treat sexual dysfunction disorders up to a maximum of 8 doses in a 30-day period or 24 doses in any 90-day period. Most drugs can be mailed from our mail order pharmacy. Some drugs (for example, drugs that are extremely high cost, require special handling, have standard packaging or requested to be mailed outside the state of Georgia) may not be eligible for mailing and/or a mail order discount. The pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan pharmacy can tell you if a drug you take is one of these drugs).
- **A generic equivalent will be dispensed if it is available**, unless your Plan provider specifically requires a brand-name drug. If you request a brand-name drug on the formulary when your Plan provider has prescribed an approved generic drug, you pay your brand-name drug copayment plus the difference in price between the generic drug and your requested brand-name drug.
- **Why use generic drugs?** 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.

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies	**High Option**	**Standard Option**	**Prosper**
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: • Drugs and medications that, by federal law, require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies, limited to glucose test strips, home glucose monitoring supplies and acetone test tablets • Disposable needles and syringes for the administration of covered medications • Compound drugs • Immunosuppressant drugs required as a result of a covered transplant • Growth hormone therapy (GHT) - in limited circumstances for treatment of children with Turner's syndrome or classical growth hormone deficiency, only with prior approval by Plan physicians • Drugs to treat gender dysphoria, including hormones and androgen blockers Notes: • For information about mail order discounts, see "These are the dispensing limitations" in the introduction to Section 5(f). • You will be charged your applicable generic or brand name drug copayment depending on the compound drug's main ingredient, whether the main ingredient is a generic drug or brand name drug. • A compound drug is one in which two or more drugs or pharmaceutical agents are combined together. We limit coverage to products listed in our drug formulary or when one of the ingredients requires a prescription by law. • Growth hormone requires our prior approval. See Section 3, *Services requiring our prior approval.*	**Plan medical office pharmacy:** $5 for preferred generic drugs, $10 for non-preferred generic drugs, $45 for preferred and non-preferred brand name drugs, and $100 for specialty drugs up to a 30-day supply. **Plan participating community pharmacy:** $15 for preferred generic drugs, $20 for non-preferred generic drugs, $55 for preferred and non-preferred brand name drugs and $100 for specialty drugs up to a 30-day supply.	**Plan medical office pharmacy:** $5 for preferred generic drugs, $10 for non-preferred generic drugs, $45 for preferred brand name drugs, $55 for non-preferred brand name drugs, and $150 for specialty drugs up to a 30-day supply **Plan participating community pharmacy:** $20 for preferred generic drugs, $25 for non-preferred generic drugs, $55 for preferred brand name drugs, $65 for non-preferred brand name drugs, and $150 for specialty drugs up to a 30-day supply	**Plan medical office pharmacy:** $5 for preferred generic drugs, $10 for non-preferred generic drugs, $45 for preferred brand name drugs, $65 for non-preferred brand name drugs, and $200 for specialty drugs up to a 30-day supply **Plan participating community pharmacy:** $20 for preferred generic drugs, $25 for non-preferred generic drugs, $55 for preferred brand name drugs, $75 for non-preferred brand name drugs, and $200 for specialty drugs up to a 30-day supply
• Intravenous fluids and medications for home use	Nothing	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Prosper**
Contraceptive drugs and devices as listed in the ACA/HRSA site. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • We cover contraceptive drugs and devices, including implanted contraceptive devices, diaphragms, hormonal contraceptive methods, and prescribed FDA approved over-the-counter women's contraceptives and devices • We cover non-preferred contraceptives if they would otherwise be covered, and a Plan provider receives an approved drug formulary exception. • We cover prescribed FDA approved over-the-counter women's contraceptives and devices when prescribed by a Plan provider and obtained at a Plan pharmacy.	Nothing	Nothing	Nothing
• Sexual dysfunction drugs	50% of our allowance	50% of our allowance	*All charges*
• Fertility drugs, including drugs for in vitro fertilization Note: For in vitro fertilization only, we cover fertility drugs prescribed by non-Plan providers when obtained at a Plan pharmacy.	50% of our allowance	50% of our allowance	50% of our allowance
• Prescribed tobacco cessation medications, including prescribed over-the-counter medications, approved by the FDA to treat tobacco dependence	Nothing	Nothing	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Prescriptions filled at a non-Plan pharmacy, except for out-of-area emergencies as described in Section 5(d), Emergency services/accidents*	*All charges*	*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**	**Prosper**
• *Vitamins, nutrients and food supplements that can be purchased without a prescription, unless they are included in our drug formulary or listed as covered above or below* • *Over-the-counter (nonprescription) drugs, including prescription drugs for which there is an over-the-counter drug equivalent available, unless listed as covered above* • *Over-the-counter drugs unless they are included in our drug formulary or listed as covered above* • *Prescription drugs not on our drug formulary, unless approved through an exception process* • *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* • *Replacement of lost, stolen or damaged prescription drugs and accessories* • *Drugs related to non-covered services, except as stated above* • *Drugs for the promotion, prevention, or other treatment of hair loss or growth* • *Contraceptive devices, except as listed above* • *Infant formulas* • *Immunizations and other drugs and supplies needed for travel*	*All charges*	*All charges*	*All charges*
Preventive care medications	**High Option**	**Standard Option**	**Prosper**
The following are covered: • Aspirin to reduce the risk of heart attack • Oral fluoride for children to reduce the risk of tooth decay • Folic acid for women to reduce the risk of birth defects • Medication to reduce the risk of breast cancer	Nothing	Nothing	Nothing

Preventive care medications - continued on next page

Benefit Description	You pay		
Preventive care medications (cont.)	**High Option**	**Standard Option**	**Prosper**
Note: Preventive medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by a Plan pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing	Nothing	Nothing
Not covered: • *Prescriptions filled at a non-Plan pharmacy, except for emergencies as described in Section 5(d), Emergency services/accidents* • *Vitamins, nutritional and herbal supplements that can be purchased without a prescription, unless they are included in our drug formulary or listed as covered above* • *Over-the-counter drugs, unless included in our drug formulary or listed as covered above* • *Prescription drugs not on our drug formulary, unless approved through an exception process* • *Any requested packaging of drugs other than the dispensing pharmacy's standard packaging* • *Replacement of lost, stolen or damaged prescription drugs and accessories* • *Drugs related to non-covered services, except as stated above*	*All charges*	*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.
- You can receive covered Dental benefit services from participating Delta Dental PPO dentists, Delta Dental Premier dentists and non-participating dentists.
- The High and Standard Option do not have a calendar year deductible.
- The calendar year deductible for Prosper is $250 per person ($500 per family). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" when the calendar year deductible applies.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c), *Hospital benefits*, for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your 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		
Accidental injury benefit	**High Option**	**Standard Option**	**Prosper**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury and all services must be completed within 365 days of the injury in order to be covered. • 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.	50% of our allowance	50% of our allowance	50% of our allowance
Not covered: • *Services for conditions caused by an accidental injury occurring before your eligibility date*	*All charges*	*All charges*	*All charges*

Dental Benefits	You Pay		
Preventive dental	**High Option**	**Standard Option**	**Prosper**
Diagnostic and preventive dental services when provided by a Delta Dental PPO dentist, Delta Dental Premier or any licensed dentist: • Routine oral examinations - twice per calendar year • Cleaning (prophylaxis) - twice per calendar year (excluding periodontal prophylaxis) • Topical application of fluoride - twice per calendar year • Bitewing X-rays - twice per calendar year for children through age 17 and once per calendar year for adults age 18 and over • Full mouth series X-rays - once every five years Note: You may choose to receive preventive dental benefits from any licensed dentist. Delta Dental dentists agree to negotiated fee schedules as payment in full, and your coinsurance is based on a dentist's fee schedule. Your out-of-pocket costs may be lower if you choose a Delta Dental PPO dentist, rather than a Delta Premier or non-Delta dentist as well. For a list of Delta Dental PPO or Delta Dental Premier dentists, please call Delta Dental at 800-521-2651 or go to www.deltadentalins.com	30% of the dentist's usual and customary fee schedule or the fee actually charged, whichever is less	30% of the dentist's usual and customary fee schedule or the fee actually charged, whichever is less	*All charges*
Other dental benefits	**High Option**	**Standard Option**	**Prosper**
Non-surgical treatment of temporomandibular joint (TMJ) disorder, including splints and appliances	50% of our allowance	50% of our allowance	50% of our allowance
General anesthesia and associated hospital or ambulatory surgery facility charges in conjunction with dental care are covered for members: • 7 years of age or younger • Who are developmentally disabled • Who are not able to have dental care under local anesthesia due to a neurological or medically compromising condition • Who have sustained extensive facial or dental trauma	Nothing See Section 5(c) for facility charges.	Nothing See Section 5(c) for facility charges.	Nothing See Section 5(c) for facility charges.
• Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease • Extraction of bony impacted teeth	$150 per office visit	$200 per office visit	$250 per office visit after the deductible
Not covered: • *Other dental services not specifically shown as covered*	*All charges*	*All charges*	*All charges*

Section 5(h) Wellness and Other Special Features

Feature	Description
Centers for Excellence	The Centers of Excellence program began in 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted "Centers of Excellence" for certain specialized medical procedures. We have developed a nationally contracted network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.
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).
High risk pregnancies	Early intervention is a hallmark of Kaiser Permanente's prenatal care program. Prenatal care screenings can help detect or prevent many adverse health outcomes and identify members with high-risk pregnancies. In Kaiser Permanente's patient-centered model of care, the care plan for patients with high-risk pregnancies is determined based on the patient's unique needs and condition. This may include ultrasounds, fetal monitoring, and/or additional in-person prenatal visits, and supportive touchpoints with nurses or other care coordinators.
Rewards	Take steps to improve your well-being by completing the Kaiser Permanente Total Health Assessment and a biometric screening. FEHB subscribers and their enrolled spouses (age 18 and over) are eligible to receive $250 for completing a confidential, online, Total Health Assessment (available in English or Spanish) and being up to date on the following biometric screenings: blood glucose, blood pressure, Body Mass Index (BMI) and total cholesterol. To view and determine the status of your screenings, go to www.kp.org/feds. If you have not had these screenings recently, you may be required to contact your Kaiser Permanente doctor. You will get a picture of your overall health and a customized action plan with tips and resources to improve your well-being.

	You must accept the Wellness Program Agreement to be eligible to earn rewards. Please go to www.kp.org/feds to learn how to earn your reward and to view and track the status of your reward activities. You must complete the Total Health Assessment and biometric screening during the plan year. We will issue you a Kaiser Permanente Health Payment Card 4-6 weeks after you complete both activities. We will send each eligible member their own debit card. You may use your Health Payment Card to pay for certain qualified medical expenses, such as: • Copayments for office visits, prescription drugs and other services at Kaiser Permanente or other providers • Prescription eyeglasses or contacts • Dental services • Over-the-counter medication for certain diseases • Other medical expenses, as permitted by the IRS Please keep your card for use in the future. As you complete activities, we will add rewards to your card. We will not send you a new card until the card expires. Rewards you earn during this calendar year may be used until March 31 of the next calendar year. Funds are forfeited if you leave this plan. For more information, please go to www.kp.org/feds. If you have questions about completing a Total Health Assessment or class, you may call us at **866-300-9867**. If you have questions about your account balance or what expenses the Health Payment Card can be used for, you may call the phone number on the back of your Health Payment Card.
Services for the deaf, hard of hearing or speech impaired	We provide a TTY/text phone number at: 711. Sign language services are also available.
Services from other Kaiser Permanente regions	When you visit a different Kaiser Foundation Health Plan service area, you can receive visiting member services from designated providers in that area. Visiting member services are subject to the terms, conditions and cost-sharing described in this FEHB brochure. Certain services are not covered as a visiting member. For more information about receiving visiting member services, including provider and facility locations in other Kaiser Permanente service areas, please call our Away from Home Travel Line at 951-268-3900 or visit kp.org/travel.
Student coverage outside the service area	We provide a limited benefit to eligible members who are full-time registered college students (at least 12 credit hours per semester) attending a recognized accredited institution outside Kaiser Permanente's service areas and within the United States. These benefits are in addition to your emergency benefits and will be applied before your travel benefit. • We cover routine, continuing and follow-up medical care. • You pay 20% of the usual and customary charges. • Your benefit is limited to $1,200 each calendar year. • There is no deductible. • You must certify the member's student status annually. • For more information about this benefit call our Member Services Department at 404-261-2590 (TTY: 711). • File claims as shown in Section 7. The following services are not included in your out-of-area student coverage benefit:

	• Dental services • Transplants and transplant follow-up care • Services provided outside the United States
Tobacco cessation	Kaiser Permanente offers smoking cessation classes as described under Educational classes and programs in Section 5(a). In addition to the classes we also offer the following: • Kaiser Permanente's "Great Start" Quit Line is free and available for pregnant women 24 hours a day. • Free smoking cessation resources are available, including a self-help booklet for pregnant women, as well as brochures for adults and teens. • Bookmark listing of smoking cessation resources • Bi-Annual smoking cessation resource outreach mailings to all identified smokers For more information or to order any of the above materials please call our Member Services Department at 404-261-2590 (TTY: 711).
Travel Benefit	Kaiser Permanente's travel benefit for Federal employees provides you with outpatient follow-up and/or continuing medical and mental health and substance use care when you are temporarily (for example, on a temporary work assignment or attending school) outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency services/ accident benefit and include: • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast. • Outpatient continuing care for covered services for conditions diagnosed and treated within the previous 12 months by a Kaiser Permanente healthcare provider or affiliated Plan provider. Services include dialysis and prescription drug monitoring. You pay $25 for each follow-up or continuing care office visit. This amount will be deducted from the reimbursement we make to you or to the provider. We limit our payment for this travel benefit to no more than $1,200 each calendar year. For more information about this benefit call our Member Services Department at 404-261-2590 (TTY: 711). File claims as shown in Section 7. The following are a few examples of services not included in your travel benefits coverage: • Non-emergency hospitalization • Infertility treatments • Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area • Transplants • Durable medical equipment (DME) • Prescription drugs • Home health services

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**. The 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 appeals must follow their guidelines. For additional information contact the plan at 877-KP4-FEDS (877-574-3337) (TTY: 711).

Dental Plan Group #78567 -DeltaCare USA 800-422-4234

DeltaCare USA program has set copayments and no annual deductibles or maximums for covered benefits. You select a dentist in the DeltaCare USA network that is most convenient for you and your family from whom you receive treatment. Coverage includes X-rays, extractions, root canals, dentures, filings, crowns, orthodontic and periodontal services.

Contact DeltaCare USA or visit www.kp.org/feds to download our dental programs brochure for details about how to enroll, premiums and coverage.

Health classes and programs - www.kp.org/classes

As a Kaiser Permanente member, you can sign up for in-person, over-the-phone, and online wellness programs and classes designed to help you achieve your health goals. All sessions are taught by your team of experts who walk you through how to make actionable lifestyle changes.

Fitness deals -www.kp.org/exercise

As a Kaiser Permanente member, you can stay fit with a variety of reduced rates on studios, gyms, fitness gear, and online classes.

- **ClassPass** makes it easier for you to work out from anywhere. ClassPass partners with 40,000 gyms and studios around the world and offers a range of classes including yoga, dance, cardio, boxing, Pilates, boot camp, and more. You can get unlimited on-demand video workouts at no cost and reduced rates on membership plans to book in-person fitness classes and reserve gym time.
- **'Active&Fit' Direct®.** As a Kaiser Permanente member, you get access to more than 11,600 gyms with one membership when you sign up for an 'Active&Fit' Direct "standard network" membership. You can visit any of the participating fitness centers in the nationwide 'Active&Fit' Direct network. Additional "premium network" gyms may be available for additional costs.
- **ChooseHealthy®** provides you with reduced rates on a variety of fitness, health, and wellness products. This includes activity trackers, online tools to help manage your health, workout apparel, and exercise equipment.

Emotional Wellness and Coaching Apps -www.kp.org/selfcareapps

Kaiser Permanente members get access to wellness apps that can help you navigate life’s challenges and receive support for emotional wellness. Get help with anxiety, stress, sleep, relationships, and more, anytime you need it.

- **Calm** is an app for meditation and sleep designed to lower stress, reduce anxiety, and more. You can choose from more than 100 programs and activities, including guided meditations, sleep stories, and mindful movement videos.
- **myStrength** allows you to build a personalized plan. You can set mental health goals, learn coping skills, track your progress over time, and make positive changes.
- **ginger** allows you to text one-on-one with an emotional support coach anytime, anywhere, for up to 90 days each year.You can discuss goals, share challenges, and create an action plan with your coach.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

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

We do not cover the following:

- When a service is not covered, all services, drugs or supplies related to the non-covered service are excluded from coverage, except when specifically stated as covered in this brochure or for services we would otherwise cover to treat complications of the non-covered service.
- Fees associated with non-payment (including interest), missed appointments and special billing arrangements.
- Care by non-Plan providers except for authorized referrals, emergencies, travel benefit, or services from other Kaiser Permanente Plans (see Emergency services/accidents).
- 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 from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service
- Services provided or arranged by criminal justice institutions for members confined therein.
- Services or supplies we are prohibited from covering under the Federal law.

Section 7. Filing a Claim for Covered Services

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

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

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

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call our Member Service Call Center at 404-261-2825 (TTY: 711).

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

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider 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:

Kaiser Permanente
Claims Administration
P.O. Box 190849
Atlanta, GA 31119-0849

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

Notice Requirements

If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call Member Services at the phone number found on your ID card, Plan brochure, or Plan website.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing, Attention: Member Services Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736 or calling 888-865-5813.

Our reconsideration will not take in account the initial decision. The review will not be conducted by the same person or his/her subordinate, who made the initial decision.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Kaiser Foundation Health Plan of Georgia, Inc., Attention: Appeals Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736; 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, FEHB 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 healthcare 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 or notify you of the status of OPM's review within 60 days. There are no other administrative appeals.

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

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

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

Note: **If you have a serious or life-threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 404-261-2590 (locally in the metropolitan Atlanta area) or 888-865-5813 (long distance). We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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 processes the benefit, we will pay what is left of our allowance, up to our regular benefit, except Medicare-eligible members with Original Medicare as primary payor must pay cost-sharing described in this FEHB brochure (see Sections 4 and 5, members with Medicare should also see the Original Medicare Plan portion of this Section 9). We will not pay more than our allowance. If we are the secondary payor, and you received your services from Plan providers, we may bill the primary carrier.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare 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 or employing 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**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

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.

- **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 or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

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

When third parties cause illness or injuries

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

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

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

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

To secure our rights, we will have a lien on and reimbursement right to the proceeds of any judgment or settlement you or we obtain. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are entitled to full recovery regardless of whether any liability for payment is admitted by a person entity or insurer. We are entitled to full recovery regardless of whether settlement or judgment received by you identifies the medical benefits provided or purports to allocate any portion of the settlement or judgment to payment to expenses other than medical expenses. We are entitled to recover from any and all settlements, even those designated as for pain and suffering, non-economic damages and/or general damages only.

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney and any insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent. You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must notify us within 30 days of the date you or someone acting on your behalf notifies anyone, including an insurer or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury or illness. You must not take any action that may prejudice our right of recovery.

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

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

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

Surrogacy Agreements

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

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

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

Trover Solutions, Inc.
Kaiser Permanente Georgia Surrogacy Mailbox
9390 Bunsen Parkway
Louisville, KY 40220

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

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

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

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

Clinical trials

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

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

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

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. This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www.medicare.gov

- **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 404-233-3700 (locally in the metropolitan Atlanta area) or 800-232-4404 (long distance) (TTY: 711), 8 a.m. to 8 p.m., 7 days a week, or visit our website at www.kp.org/feds.

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

- **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.

- **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 member may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Part B premium reimbursement**

We offer a program designed to help members with their Medicare Part B premium. This program is called "Senior Advantage 2". For each month you are enrolled in Senior Advantage 2, have Medicare Parts A and B and are enrolled in Senior Advantage for Federal Members, you will be reimbursed up to $200 (up to $2,400 per year) of your Medicare Part B monthly premium and extra charges added to the Part B premium (Part B Late Enrollment Penalty, or LEP, and Part B Income-Related Monthly Adjustment Amount, or IRMAA). In addition to reimbursing for the Part B premium, we will cover additional benefits, including lower copayments for office visits, outpatient surgery, inpatient hospital care, emergency care, generic and brand-name prescription drugs and the SilverSneakers® fitness program.

You may enroll in this program if:

- You enroll in Kaiser Permanente's High Option or Standard Option,
- You live in our Medicare Advantage Service area,
- You enroll in Senior Advantage for Federal Members, and
- The FEHB subscriber completes an additional application for enrollment in Senior Advantage 2.

Reimbursement will begin on the first of the month following receipt of your additional application for enrollment in Senior Advantage 2 and verification of your Medicare Part B enrollment. During a calendar year, you may enroll in Senior Advantage 2 only once. If the FEHB subscriber enrolls in Senior Advantage 2, each family member who enrolls in Senior Advantage for Federal Members is required to participate in Senior Advantage 2. If, for any reason, you do not meet the enrollment requirements for Senior Advantage 2, you will no longer be eligible to participate in the program. Your reimbursements will end and your regular FEHB High Option or Standard Option benefits will resume. You may be required to repay any reimbursement paid to you in error.

To learn more about Senior Advantage 2 and how to enroll, call us at 404-233-3700 (locally in the metropolitan Atlanta area) or 800-232-4404 (TTY:711), 8 a.m. to 8 p.m., 7 days a week, or visit our website at kp.org/feds.

- **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 healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at **800-MEDICARE (800-633-4227) (TTY: 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. High and Standard Option Members can choose between 1 Medicare Advantage plans: "Senior Advantage 1" (richest benefits) and "Senior Advantage 2" (some rich benefits) and Part B premium reimbursement. If you live in our Senior Advantage service area and you have Medicare Parts A and B, you can enroll in Senior Advantage for Federal Members. Enrolling in Senior Advantage for Federal Members does not change your FEHB premium. Your enrollment is in addition to your FEHB High Option, Standard Option or Prosper enrollment; however, your benefits will be provided under the Kaiser Permanente Senior Advantage for Federal Members plan and are subject to all Medicare rules. If you have Medicare Parts A and B, you can enroll in Senior Advantage for Federal Members with no increase to your FEHB or Kaiser Permanente premium.

If you are considering enrolling in Senior Advantage for Federal Members, please call us at 404-233-3700 (locally in the metropolitan Atlanta area) or 800-232-4404 (long distance) (TTY: 711), 8 a.m. to 8 p.m., 7 days a week, or visit our website at www.kp.org/feds.

With Kaiser Permanente Senior Advantage for Federal Members, you will get more coverage, such as lower cost sharing and additional benefits. This 2024 benefit summary allows you to make a comparison of your choices:

Benefit Description: Deductible
High Option You Pay Without Medicare: None
High Option Senior Advantage 1 You Pay: None
High Option Senior Advantage 2 You Pay: None
Standard Option You Pay Without Medicare: None
Standard Option Senior Advantage 1 You Pay: None
Standard Option Senior Advantage 2 You Pay: None
Prosper You Pay Without Medicare: $250
Prosper Senior Advantage You Pay: None

Benefit Description: Primary Care
High Option You Pay Without Medicare: $15 (No charge for children through age 17)
High Option Senior Advantage 1 You Pay: $0 (No charge for children through age 17)
High Option Senior Advantage 2 You Pay: $10 (No charge for children through age 17)
Standard Option You Pay Without Medicare: $20 (No charge for children through age 17)
Standard Option Senior Advantage 1 You Pay: $10 (No charge for children through age 17)
Standard Option Senior Advantage 2 You Pay: $20 (No charge for children through age 17)
Prosper You Pay Without Medicare: $20
Prosper Senior Advantage You Pay: $20

Benefit Description: Specialty Care
High Option You Pay Without Medicare: $30
High Option Senior Advantage 1 You Pay: $20
High Option Senior Advantage 2 You Pay: $25
Standard Option You Pay Without Medicare: $40
Standard Option Senior Advantage 1 You Pay: $25
Standard Option Senior Advantage 2 You Pay: $30
Prosper You Pay Without Medicare: $40
Prosper Senior Advantage You Pay: $30

Benefit Description: Outpatient Surgery
High Option You Pay Without Medicare: $150
High Option Senior Advantage 1 You Pay: $20
High Option Senior Advantage 2 You Pay: $50
Standard Option You Pay Without Medicare: $200
Standard Option Senior Advantage 1 You Pay: $100
Standard Option Senior Advantage 2 You Pay: $120
Prosper You Pay Without Medicare: $250*
Prosper Senior Advantage You Pay: $150

Benefit Description: Inpatient Hospital Care
High Option You Pay Without Medicare: $500 per admission ($250 per admission for maternity)
High Option Senior Advantage 1 You Pay: $100 per admission, (No charge for maternity)
High Option Senior Advantage 2 You Pay: $250 per admission
Standard Option You Pay Without Medicare: $750 per admission (No charge for maternity)
Standard Option Senior Advantage 1 You Pay: $250 per admission
Standard Option Senior Advantage 2 You Pay: $400 per admission
Prosper You Pay Without Medicare: $750* per admission
Prosper Senior Advantage You Pay: $350 per admission

Benefit Description: Part B Reimbursement
High Option Without Medicare: Not Applicable
High Option Senior Advantage 1: None
High Option Senior Advantage 2: Up to $200 monthly
Standard Option Without Medicare: Not Applicable
Standard Option Senior Advantage 1: None
Standard Option Senior Advantage 2: Up to $200 monthly
Prosper Without Medicare: Not Applicable
Prosper Senior Advantage: None

Benefit Description: Additional Benefits Offered
High Option Without Medicare: Not applicable
High Option Senior Advantage 1: Eyeglasses and contact lenses allowance; SilverSneakers; OTC Allowance; Transportation Allowance
High Option Senior Advantage 2: SilverSneakers; OTC Allowance; Transportation Allowance
Standard Option Without Medicare: Not applicable
Standard Option Senior Advantage 1: SilverSneakers; OTC Allowance; Transportation Allowance
Standard Option Senior Advantage 2: SilverSneakers; OTC Allowance; Transportation Allowance
Prosper Without Medicare: Not applicable
Prosper Senior Advantage: SilverSneakers; OTC Allowance; Transportation Allowance

Benefit Description: Out-of-Pocket Maximum (2x per family)
High Option You Pay Without Medicare: $4,000 per person
High Option Senior Advantage 1 You Pay: $2,000 per person
High Option Senior Advantage 2 You Pay: $2,000 per person
Standard Option You Pay Without Medicare: $5,000 per person
Standard Option Senior Advantage 1 You Pay: $2,500 per person
Standard Option Senior Advantage 2 You Pay: $2,500 per person
Prosper You Pay Without Medicare: $6,500 per person
Prosper Senior Advantage You Pay: $3,250 per person

* You pay the deductible, then cost-sharing

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This is a summary of the features of the Kaiser Permanente Senior Advantage for Federal Members. As a Senior Advantage member, you are still entitled to coverage under the FEHB Program. All benefits are subject to the definitions, limitations, and exclusions set forth in this FEHB brochure and the Kaiser Permanente Senior Advantage for Federal Members Evidence of Coverage.

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

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement or employing 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		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

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

Clinical trials cost categories

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

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

Coinsurance

See section 4, page 22.

Copayment

See Section 4, page 22.

Cost-sharing

See Section 4, page 22.

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 medication. (2) Care that can be performed safely and effectively by people whom, 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

See Section 4, page 22.

Experimental or investigational service

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

Healthcare 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. Healthcare coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Healthcare coverage purchased through membership in an organization is also "group health coverage."

Healthcare professional

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

Hospice care

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. If you make a hospice election, you are not entitled to receive other healthcare 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.

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/serious reportable 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.

Observation care

Hospital outpatient services you get while your physician decides whether to admit you as an inpatient or discharge you. You can get observation services in the emergency department or another area of the hospital.

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 services subject to federal or state surprise billing laws, the amount that we are required to pay (see Section 4 for more information about surprise billing).
- 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 the Kaiser Permanente would have paid if it did not subtract cost-sharing.

You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

Post-service claims

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

Pre-service claims

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

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier Charges for Covered Services out of the payment to the extent of the Covered Services provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or workers' compensation program or insurance policy, as a successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from the carriers health benefits plan.

Surprise bill

An unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by non-Plan providers with respect to patient visits to Plan health care facilities, or for
- air ambulance services furnished by non-Plan providers of air ambulance services.

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 determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Member Services at 404-261-2590 (locally in the metropolitan Atlanta area) or 888-865-5813 (long distance). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to Kaiser Foundation Health Plan of Georgia, Inc.

You

You refers to the enrollee and each covered family member.

Index

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

Notes

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Summary of Benefits for the High Option of Kaiser Permanente - Georgia - 2024

- **Do not rely on this chart alone**. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.kp.org/feds.
- 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	$15 per primary care office visit (Nothing for children through age 17) $30 per specialty care office visit	28
Services provided by a hospital: Inpatient	$500 per admission $250 per admission for maternity	54
Services provided by a hospital: Outpatient	$150 per visit	55
Emergency benefits:	$200 per visit	59
Mental health and substance use disorder treatment:	Regular cost-sharing	62
Prescription drugs (up to a 30-day supply): Plan medical office pharmacy	$5 copay preferred generic, $10 copay non-preferred generic, $45 copay preferred and non-preferred brand drugs, $100 copay specialty drugs Up to a 90-day supply of most drugs for 2 copays through our mail order program	67
Prescription drugs (up to a 30-day supply): Plan participating community pharmacy	$15 copay preferred generic, $25 copay non-preferred, $55 copay preferred and non-preferred brand drugs, $100 copay specialty drugs	67
Dental care:	Various cost-shares based on procedure	71
Vision care: Exam	$30 per office visit	38
Special features: Flexible benefits option; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Tobacco cessation; Student coverage outside the service area; Travel benefit; Rewards	See Section 5(h) for more information	73
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $4,000 for Self Only enrollment or $8,000 for Self and Family enrollment. Some costs do not count toward this protection.	23

Summary of Benefits for the Standard Option of Kaiser Permanente - Georgia - 2024

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.kp.org/feds.
- 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 (Nothing for children through age 17) $40 per specialty care office visit	28
Services provided by a hospital: Inpatient	$750 per admission Nothing per admission for maternity	54
Services provided by a hospital: Outpatient	$200 per visit	55
Emergency benefits:	$200 per visit	59
Mental health and substance use disorder treatment:	Regular cost-sharing	62
Prescription drugs (up to a 30-day supply): Plan medical office pharmacy	$5 copay preferred generic, $10 copay non-preferred generic, $45 copay preferred brand drugs, $55 copay non-preferred brand drugs, $150 copay specialty drugs Up to a 90-day supply of most drugs for 2 copays through our mail order program	67
Prescription drugs (up to a 30-day supply): Plan participating community pharmacy	$20 copay preferred generic, $25 copay non-preferred generic, $55 copay preferred brand drug, $65 copay non-preferred brand drug, $150 copay specialty drugs	67
Dental care:	Various cost-shares based on procedure	71
Vision care: Exam	$40 per visit	38
Special features: Flexible benefits option; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Tobacco cessation; Student coverage outside the service area; Travel benefit; Rewards	See Section 5(h) for more information	73
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000 for Self Only enrollment or $10,000 for Self and Family enrollment. Some costs do not count toward this protection.	23

Summary of Benefits for Prosper of Kaiser Permanente - Georgia - 2024

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.kp.org/feds.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the calendar year deductible.

Prosper Benefits	You pay	Page
Calendar year deductible for covered services:	$250 per person $500 per family	22
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	28
Services provided by a hospital: Outpatient	$250* per visit	55
Services provided by a hospital: Inpatient	$750* per admission	54
Emergency benefits:	$250 per visit	59
Mental health and substance use disorder treatment:	Regular cost-sharing	62
Prescription drugs (up to a 30-day supply): Plan participating community pharmacy	$20 copay preferred generic, $25 copay non-preferred generic, $55 copay preferred brand drugs, $75copay non-preferred drugs, $200 copay specialty drugs	67
Prescription drugs (up to a 30-day supply): Plan medical office pharmacy	$5 copay preferred generic, $10 copay non-preferred generic, $45 copay preferred brand drugs, $65 copay non-preferred brand drugs, $200 copay specialty drugs Up to a 90-day supply of most drugs for 2 copays through our mail order program	67
Dental care:	Various cost-share based on procedure	71
Vision care: Exam	$40 per visit	38
Special features: Flexible benefits option; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Tobacco cessation; Student coverage outside the service area; Travel benefit; Rewards	See Section 5(h) for more information	73
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $6,500 for Self Only enrollment or $13,000 for Self and Family enrollment. Some costs do not count toward this protection.	23

2024 Rate Information for Kaiser Permanente - Georgia

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to **www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.**

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option Self Only	F81	$271.43	$156.21	$588.10	$338.45
High Option Self Plus One	F83	$586.50	$379.95	$1,270.75	$823.23
High Option Self and Family	F82	$646.18	$320.27	$1,400.06	$693.92
Standard Option Self Only	F84	$251.42	$83.81	$544.75	$181.58
Standard Option Self Plus One	F86	$568.23	$189.41	$1,231.16	$410.39
Standard Option Self and Family	F85	$568.23	$189.41	$1,231.16	$410.39
Prosper Self Only	LA1	$175.22	$58.40	$379.64	$126.54
Prosper Self Plus One	LA3	$395.99	$131.99	$857.97	$285.99
Prosper Self and Family	LA2	$454.91	$151.63	$985.63	$328.54