Kaiser Permanente Washington Options Federal

www.kp.org/wa/fehb-options

Member Services: 888-901-4636

2018

A Prepaid Comprehensive Medical Plan (Standard Option) with a Point of Service product, and a High Deductible Health Plan

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details. This plan is accredited. See page 14

Serving: All of Washington state

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 16 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2018: Page 17
- Summary of benefits: Page 148

Special Notice for High Option members: We have eliminated the High Option (Enrollment code VT). We will automatically transfer you to the Standard Option (Enrollment code L1), if you do not enroll in another plan or option during Open Season. See page 17 for benefit changes and page 150 for rates.

Enrollment codes for this Plan:

L11 Standard Option – Self Only
L13 Standard Option – Self Plus One
L12 Standard Option – Self and Family

L14 High Deductible Health Plan (HDHP) – Self Only
L16 High Deductible Health Plan (HDHP) – Self Plus One
L15 High Deductible Health Plan (HDHP) – Self and Family

Authorized for distribution by the:

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

RI 73-051

Important Notice from Kaiser Permanente Washington Options Federal About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Kaiser Permanente Washington Options Federal 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's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You 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 Coordination 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 www.socialsecurity.gov, or call the SSA at 800-772-1213 (TTY 800-325-0778).

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

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227. TTY: 877-486-2048.

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Introduction

This brochure describes the benefits of Kaiser Foundation Health Plan of Washington Options, Inc. d/b/a "Kaiser Permanente Washington Options Federal", "Options Federal" or "Kaiser Permanente" under our contract (CS 1767) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Member Services may be reached toll-free at 888-901-4636 or through our website: www.kp.org/wa/fehb-options. The address for Kaiser Foundation Health Plan of Washington administrative offices is:

Administrative Office:
Kaiser Foundation Health Plan of Washington Options, Inc.
MSBD GNW-C1W-04
1300 SW 27th Street
Renton, Washington 98057-9813

Mailing Address:
Kaiser Permanente
P.O. Box 34803
Seattle, Washington 98124-1803

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 and Family coverage, each eligible family member is also entitled to these benefits. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2018, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2018, and changes are summarized on page 17. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirements. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provisions for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Kaiser Permanente Washington Options Federal, Options Federal or Kaiser Permanente.
- 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 Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that 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 toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE 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 he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (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

Kaiser Foundation Health Plan of Washington Options, Inc. complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557 Kaiser Foundation Health Plan of Washington Options, Inc. does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

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 health care and that of your family members by learning more about 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 medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines 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 medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- 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 a 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 your results.
- 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 health care 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 reactions 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 health care 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 health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, 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 health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and 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 a Never Event occurs, the health care facility is required to report the event to the Washington State Department of Health in accordance with RCW 70.56.020. The health care facility should apologize to the patient, report the event, investigate the event, report its underlying cause, take corrective action to prevent similar events and waive costs directly related to the event.

In the instance of a Never Event, the health care facility agrees that it will not charge the patient or Kaiser Permanente Washington Options Federal for any and all care associated with the event, including complications which are the result of the event.

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 (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. 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, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, 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 and Family or Self Plus One 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.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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

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 a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

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

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 has implemented 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 Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self 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 Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. 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 paid according to the 2018 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2017 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).

- **Upon divorce** — If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **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). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. 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, if you are a covered dependent child and you turn 26, etc.

  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 new kind of tax 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 FEHBP 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 toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 or visit our website at www.kp.org/wa/fehb-options.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act'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

We are a Prepaid Comprehensive Medical Plan with a Point of Service product. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Kaiser Foundation Health Plan Washington Options, Inc. holds the following accreditations: accredited accreditation for Commercial HMO plans from the National Committee for Quality Assurance (NCQA), a private, non-profit organization dedicated to improving health care quality. To learn more about this plan's accreditation, please visit the following website: www.ncqa.org. This means that we offer health services in whole or substantial part on a prepaid basis, with professional services provided by individual physicians who agree to accept the payments provided by the Plan and the members' cost-sharing amounts as full payment for covered services. We give you a choice of enrollment in a Standard Option, or a High Deductible Health Plan (HDHP).

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

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

Questions regarding what protections apply may be directed to us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our Standard Option

The Standard option provides comprehensive medical, surgical and hospitalization benefits in addition to coverage for alternative care providers, preventive dental benefits, mental health care, and an open drug formulary prescription benefit.

We have Point of Service (POS) benefits

Our Plan offers POS benefits. This means you can receive covered services from a non-Plan provider. However, out-of-network benefits may have higher out-of-pocket costs than our in network benefits. Please see Standard Option Section 5(i), page 72, for POS benefit details.

How we pay providers

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

We emphasize comprehensive medical and surgical care received from Plan providers. A Plan provider is any facility or licensed practitioner who contracts with the Plan, the First Choice Health Network (FCHN), or First Health Network. A Plan pharmacy is a pharmacy contracted with our pharmacy benefit management company and a Plan dentist is any licensed dentist within Washington state.

To receive the highest level of benefits, you must use Plan providers, pharmacies, and dentists.

When you reside outside the state of Washington under any of the following conditions, 1) part-time, 2) as a dependent child, or 3) on Temporary Duty Assignment, a Plan provider is a First Health Network provider; or in Alaska, Idaho, Montana, and Oregon, a Plan provider is a First Choice Health Network provider. If you are in an area where Plan providers are difficult to access (e.g., 50 miles from home or work), please contact us to confirm that we will pay a non-Plan provider at the non-Plan provider rate based on the billed amount rather than our allowed amount, which will eliminate the non-Plan provider "balance billing" you. You can reach us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711.

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services: Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a Plan provider. Preventive dental care is paid on a fee basis and may result in "balance billing" by your dentist.

Annual deductible: The annual deductible must be met before Plan benefits are applied, except for preventive medical care services, preventive dental care, and tobacco cessation treatment and medications when received through the Quit For Life® program.

Health Savings Account (HSA):
You are eligible for an HSA if you:

- Are enrolled in an HDHP;
- Are not covered by any other health plan that is not an HDHP (including a spouse's health plan, but not including specific injury insurance and accident, disability, dental care, vision care, or long-term coverage);
- Are not enrolled in Medicare;
- Have not received VA or Indian Health Services (IHS) benefits within the last three months;
- Are not covered by your own or your spouse's flexible spending account (FSA); and
- Are not claimed as a dependent on someone else's tax return.

You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.

Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP.

You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health Plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.

You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

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

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

Catastrophic protection: We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $6,650 for Self Only enrollment, or $13,300 for a Self Plus One or Self and Family enrollment. Your specific plan limits may differ.

Health education resources and account management tools: Kaiser Permanente Washington Options Federal has chosen HealthEquity® to be our HSA and HRA administrator. As a Kaiser Permanente Washington Options Federal HDHP enrollee, you will have the following health education resources and account management tools provided or made available to you:

- A HealthEquity® new enrollee welcome letter with your account information will be mailed to you shortly after enrolling.

- Convenient access to funds is made available through a HealthEquity® Visa® account.
- At the HealthEquity® website (www.healthequity.com) you can easily view account balances and information, change investment options, download forms and link to a list of covered expenses.
- Through the HealthEquity® toll-free customer service line at 866-346-5800 you can access automated information, or speak with a helpful customer service representative.

Other important tools and information are available by visiting the Kaiser Permanente Washington Options Federal website at www.kp.org/wa/fehb-options.

For more details please refer to the HDHP **Section 5(i) Health education resources and account management tools** on page 126**.**

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, and our providers. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- We are a health care service contractor that has provided health care services to Washingtonians since 1946.
- Kaiser Foundation Health Plan of Washington Options, Inc. is a not-for-profit organization.

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 website, Kaiser Permanente Washington Options Federal at www.kp.org/wa/fehb-options. You can also contact us to request that we mail a copy to you.

If you want more information about us, call toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711, or write to P.O. Box 34803, Seattle, Washington 98124-1803. You may also visit our website at www.kp.org/wa/fehb-options.

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

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 or work in our service area. This is where our providers practice. Our service area is all of Washington state.

If you receive care from non-Plan providers in our service area, as described in "How we pay providers" on 14, we will pay benefits based on our contracted rates for Plan providers. You will be responsible for any copayments, coinsurance, deductible, and any additional balance billed by a non-Plan provider. For details regarding out-of-network services, please see Section 5(i), *Point of Service (POS) benefits* for Standard Option, page 72, and page 76 for the HDHP O*ut-of-network services.*

If you or a covered family member move outside of our service area, you can enroll in another plan. 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 2018

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 only

- We have eliminated the High Option effective January 1, 2018.

Changes to Standard Option only

- Your share of the non-Postal premium will increase for Self Only and Self Plus One enrollment. See page 150.
- Your share of the non-Postal premium will decrease for Self and Family enrollment. See page 150.
- Your share of the Postal Category 1 and Category 2 premium will increase for Self Only and Self Plus One enrollment. See page 150.
- Your share of the Postal Category 1 and Category 2 premium will decrease for Self and Family enrollment. See page 150.
- We have decreased the cost-sharing for mental health and substance misuse disorder group therapy visits to no charge. See page 61.
- The deductible will no longer apply to intravenous (IV) and infusion therapy services. You will pay nothing for home IV and you will pay the primary and specialty care office visit cost sharing for IV and infusion therapy in a medical office. See page 38.
- For professional services of out-of-network physicians in a medical office, you pay $25 per primary care office visit or $35 per specialty care visit, then you pay 40% of the Plan allowance and any difference between our allowance and the billed amount. For procedures, you also pay 40% after deductible. See Sections 5(a) and 5(e).
- We have changed the emergency room cost-sharing from 20% coinsurance to $150 copayment after the deductible. See page 60.

Changes to our High Deductible Health Plan (HDHP)

- Your share of the non-Postal premium will increase for Self Only and Self Plus One enrollment. See 150.
- Your share of the non-Postal premium will decrease for Self and Family enrollment. See 150.
- Your share of the Postal Category 1 premium will increase for Self Only, Self Plus One and Self and Family enrollment. See page 150.
- Your share of the Postal Category 2 premium will increase for Self Only and Self Plus One enrollment. See page 150.
- Your share of the Postal Category 2 premium will decrease for Self and Family enrollment. See page 150.
- We have decreased the cost-sharing for mental health and substance misuse disorder group therapy visits from 20% coinsurance to no charge after the deductible. See page 115.

Changes to Standard and HDHP Options

- We have reduced the cost share for certain statins to no charge for members that meet guidelines per the U.S. Preventive Services Task Force recommendations as required by the Affordable Care Act. See pages 67 and 122.
- We have removed the visit limits for physical, occupational and speech therapy when provided for a mental health condition. See pages 63 and 116
- We have increased the dispensing limit for contraceptives to up to a 12-month supply per prescription. See pages 64 and 118.

Benefit Clarifications

- We have updated our Plan name to Kaiser Permanente Washington Options Federal.

- We have changed the name of Customer Service to Member Services.
- We have clarified how your Out-of-pocket maximum is applied.
- We have clarified that services may be received from non-Plan providers when utilizing the Point of Service option.
- We have clarified that if you are hospitalized in a non-Plan facility you may ask to be transferred to a Plan facility.
- We have added information for the Consulting Nurse Service.
- We have updated information for Services for the deaf, hard of hearing or speech impaired individuals.
- We have added clarifying language to the Preventive Care benefit regarding the Affordable Care Act.
- We have updated the list of preventive medications.
- We have clarified that professional services of a physician at a hospital as described in Section 5(a) also applies to Section 5(e).
- We have moved the Sleep Disorder surgical information from Section 5(a) to Section 5(b).
- We have removed the detail regarding Transgender Services from Section 5(c). This allows us to provide services based on the latest available medically appropriate treatments.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711, or write to us at P.O. Box 34803, Seattle, Washington 98124-1803. You also may request replacement cards through our website at www.kp.org/wa/fehb-options and choosing Member Services.

Where you get covered care

In Washington state, you get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. If you use our Point of Service program, you also can get care from non-Plan providers in Washington state, but it will cost you more.

You get dental care from any licensed dentist within Washington state.

- **Plan providers**

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

Our provider directory lists primary care providers with their locations and phone numbers. Provider information is updated on a regular basis and is available on our website at www.kp.org/wa/fehb-options by clicking on Members/Find a Provider or upon request by calling Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. You also can find out if your doctor participates with us by calling these numbers. If you are interested in receiving care from a **specific** provider who is listed in the directory, call the provider to verify that he or she still participates with us and is accepting new patients.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update on a regular basis. This information also is available on our website at www.kp.org/wa/fehb-options by clicking on Members/Find a Provider.

What you must do to get covered care

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

- **Primary care**

Primary care providers are family practitioners, general practitioners, pediatricians, obstetricians/gynecologists, naturopaths, physician assistants (under the supervision of a physician), or advanced registered nurse practitioners (ARNPs). If your primary care provider is no longer a Plan provider, the same time frames described on page 19 under **Specialty care** will apply for you to transfer to a new primary care Plan provider.

- **Specialty care**

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

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

- If you are seeing a specialist and your specialist leaves the Plan, you will be allowed 60 days from the date we notify you that the specialist has left the Plan to either (i) complete your course of treatment, or (ii) appropriately transfer your care to another Plan provider. If, after 60 days, you have not completed your course of treatment or transferred your care to another Plan provider, your benefits will be paid at the lower Point of Service (POS) rate described in Section 5(i), *Point of Service (POS) benefits*, page 72, for Standard Option and page 76 for HDHP *Out-of-network services*.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for 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.

- **Complementary care**

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

- East Asian Medicine Practitioner (Acupuncturist)
- Chiropractor
- Massage therapist

When receiving services from these providers, you are subject to the same benefit conditions and limitations that exist for other Plan providers. In addition, spinal and extremity manipulations, acupuncture needle treatments; except for the treatment of substance misuse disorder, and massage therapy are each limited to 20 treatments per calendar year.

The non-Plan provider reduction in benefits applies (see Standard Option Section 5(i), *Point of Service benefits*, page 72, and HDHP Section 5, *High Deductible Health Plan Benefits Overview, Out-of-network services*, page 76).

- **Hospital care**

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

- **If you are 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 toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 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.

You need prior Plan approval for certain services

Since we do not have a primary care physician or a referral requirement, and we allow you to use non-Plan providers, you need to obtain our approval before you receive certain services. The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services and equipment, are detailed in this section. A pre-service claim is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care, services, or equipment. In other words, a pre-service claim for benefits (1) requires a precertification or prior approval and (2) will result in a denial or reduction of benefits if you do not obtain precertification or prior approval.

- **Inpatient hospital admission**

Precertification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. The authorization is valid for 30 days. Approval for each admission or re-admission is required. We will provide coverage only for the number of hospital days that are medically necessary and appropriate for your condition. If your hospital stay is extended due to complications, your provider must obtain benefit authorization for the extension.

After your doctor notifies you that hospitalization or skilled nursing care is necessary, ask your doctor to obtain precertification. Your doctor or care facility must request precertification before admission. This is a feature that allows you to know, prior to admission, which services are considered medically necessary and eligible for payment under this Plan.

We will send you written confirmation of the approved admission, once certification is obtained.

- **Other services**

For certain services or equipment your physician must obtain prior approval from us. Before giving approval, we consider if the service or equipment is covered, medically necessary, and follows generally accepted medical practice. Your physician or medical equipment supplier must obtain prior approval for the services, treatments, or items listed below.

Note: The list is not all inclusive and is subject to change at any time.

- Bariatric Surgery
- Certain drugs as shown on the Preferred drug list, including chemotherapy and growth hormone therapy
- Cochlear implants
- High end radiology services, such as CAT scan, MRI, PET and SPECT scans
- Inpatient facility services, such as hospital, rehabilitation, skilled nursing, mental health and substance misuse disorder treatment facilities
- Non-emergent air transportation
- Organ transplants
- Reconstructive breast surgery
- Sex transformation for gender reassignment (transgender services)
- Surgeries for sleep disorders
- TMJ surgery

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 before admission, services, or equipment requiring prior authorization are rendered.

Member Services will confirm that the service, treatment, or equipment requires preauthorization. If it does, your physician or care facility must submit a preauthorization request. All requests for prior authorization must include the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, surgery, or equipment; and (if applicable)
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

A staff nurse will review the request and send you and your provider notification in writing of the decision. The same process applies when the service or treatment is received from a non-Plan provider; or if an extension to the prior authorization is required.

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to 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 toll-free at 888-901-4636. You may also call OPM's Health Insurance 2 at (202) 606-3818 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 toll-free at 888-901-4636. 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, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

Maternity care does not require preauthorization.

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

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

What happens when you do not follow the precertification rules

If a service or treatment that requires precertification is performed either by a Plan provider/facility or a non-Plan provider/facility without obtaining the authorization, a retro-review may be done to determine if it is a covered benefit and if it was medically necessary. We will not pay for services or treatments that are not covered or that are not medically necessary.

If the hospitalization and treatment is not preauthorized, our allowance for the admitting physician's fees and benefits for the hospital stay will be reduced by 20%. The same reduction applies to inpatient mental health or substance misuse disorder treatment that is not preauthorized.

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, equipment, 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

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, supply, or equipment; or
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 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 requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

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

Help us control costs

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

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

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

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

The procedures listed below must be performed on an outpatient basis.

Note: The list is not all inclusive and is subject to change at any time.

To obtain information regarding procedures that must be performed on an outpatient basis, please contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711.

- Biopsy procedures
- Breast surgery (minor) (However, anyone who undergoes a mastectomy may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.)
- Diagnostic examination with scopes

- Dilation and curettage (D&C)
- Ear surgery (minor)
- Facial reconstruction surgery
- Hemorrhoid surgery
- Inguinal hernia surgery
- Knee surgery
- Nose surgery
- Removal of bunions, nails, hammertoes, etc.
- Removal of cataracts
- Removal of cysts, ganglions, and lesions
- Sterilization procedures
- Tendon, bone, and joint surgery of the hand and foot
- Tonsillectomy and adenoidectomy

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.

Example:

Under Standard Option, you pay a copayment of $25 (no deductible) for primary care per office visit and $35 (no deductible) for specialty care per office visit. You pay a $20 copayment for Tier 1 drugs, a $40 copayment for Tier 2 drugs and a $60 copayment for Tier 3 drugs. (Coinsurance amounts apply to Tier 4 and 5 drugs).

Under the High Deductible Health Plan (HDHP), once you have met the annual deductible, you pay a $20 copayment for Tier 1 drugs, a $40 copayment for Tier 2 drugs, and a $60 copayment for Tier 3 drugs. (Coinsurance amounts apply to Tier 4 and Tier 5 drugs.).

Deductible

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

- **The Standard Option** calendar year deductible is $350 per person.
- **Under Standard Option Self Only enrollment,** the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible reach $350.
- **Under Standard Option Self Plus One enrollment,** the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $700.
- **Under Standard Option Self and Family Enrollment**, the deductible is considered satisfied for all family members when their combined covered expenses applied to the calendar year deductible for family members reach $700.
- **The Standard Option deductible** is waived for preventive care.
- **The High Deductible Health Plan (HDHP)** calendar year deductible is $1,500 for Self Only enrollment and $1,500 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,000 (each applies separately for services received from Plan providers and non-Plan providers).

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. You pay 20% coinsurance in-network or 40% out-of-network for most services, except for infertility services that have a 50% coinsurance.

See *Your catastrophic protection out-of-pocket maximum* page 27 for more information regarding coinsurance.

Difference between our Plan allowance and the bill

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

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

If you choose a non-Plan provider, we pay 60% of our allowed amount for covered services. It is your responsibility to pay the difference between the amount billed by the non-Plan provider and the amount allowed by us. This is called "balance billing."

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

- **Medical Emergency.** Emergency care is covered in full after you have met any applicable deductible, copayment, or coinsurance. If you are admitted to a non-Plan hospital as a result of your emergency, we reserve the right to arrange for your transportation to a Plan hospital (see Section 5(d), *Emergency services/accidents*, pages 60 and 114).
- **Services Not Available from Plan Providers/Facilities.** We have the right to determine whether care and services are, or are not, available from a Plan provider or facility. If you believe the care or service you require is not available from a Plan provider or facility, please contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 ***before*** obtaining the care or service and ask for a review to determine if it is appropriate for you to see a non-Plan provider. If we determine that the care or service you require can only be obtained from a non-Plan provider, your care will be covered in full (if it is a medically necessary/covered benefit) after you have met any applicable deductible, copayment, or coinsurance.

Your catastrophic protection out-of-pocket maximum

After your cost-sharing total is $5,000 per person up to $10,000 per family enrollment 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 health care reform legislation (the Affordable Care Act and implementing regulations).

Example: Your plan has a $5,000 per person up to $10,000 per family maximum out-of-pocket limit. If you or one of your covered family members has out-of-pocket qualified medical expenses of $5,000 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 $10,000 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.

For Standard Option: 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:

- Services of non-Plan providers and facilities
- Dental services
- Expenses in excess of the Plans's allowable amount or benefit maximum (e.g., preventive dental care fee schedule amounts)

For HDHP Option: 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:

- Expenses in excess of the Plan's allowable amount or benefit maximum (e.g., preventive dental care fee schedule amounts)

Carryover

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

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

When Government facilities bill us

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

Section 5. Standard Option Benefits

See page 17 for how our benefits changed this year and page 148 for a benefits summary. Make sure that you review the benefits that are available under this option.

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Section 5. Standard Option Benefits Overview

This Plan offers a Standard Option. The benefit package is described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard Option benefits, contact us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711, or on our website at www.kp.org/wa/fehb-options.

Unique features:

- Preventive dental benefit
- Alternative care provider coverage

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.
- **For the non-Plan provider benefit see Section 5(i), *Point of Service (POS) benefits*, page 72.**

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	**Standard Option**
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion Note: You pay a copayment for office visits billed with codes corresponding to these services.	In-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Procedures received during an office visit Note: Procedures include lab, x-ray, other diagnostic procedures and surgical services. For more information, see Sections 5(a), Lab, X-ray and other diagnostic tests, and 5(b), Surgical and anesthesia services provided by physicians and other health care professionals.	In-network: 20% of Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • At a hospital - inpatient and outpatient visits • In a skilled nursing facility • At home	In-network: 20% of Plan allowance Out-of-Network: 40% of Plan allowance and any difference between our allowance and the billed amount
Virtual care: Healthcare service provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (ex. home) with an in-network provider that is diagnostic and treatment focused. The member is NOT located at a healthcare site.	In-network: Nothing (no deductible) Out-of-network: Not covered
Not covered: • *Fax and e-mail communications* • *Virtual care from a Non-Plan provider*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Telehealth Services	**Standard Option**
Telemedicine services provided by the use of real time interactive audio and video communication or time delayed transmission of medical information between the patient at the originating site and a provider at another location for diagnosis, consultation, or treatment. Services must be provided by a Washington state licensed physician.	In-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Not covered: • *Audio-only, telephone, fax and e-mail communications*	*All charges*
Lab, X-ray and other diagnostic tests	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Preventive care, adult	**Standard Option**
• One annual routine physical • One annual routine eye exam	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Routine screenings, such as: • Abdominal aortic aneurysm one time screening by ultrasonography for men with a history of smoking • Complete Blood Count, one annually • A fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides) for adults • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening - Colonoscopy screening • Annual routine Prostate Specific Antigen (PSA) test for men • Annual routine mammogram for women	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible…
Preventive care, adult (cont.)	**Standard Option**
• Breast Related Cancer Risk Assessment, Genetic Counseling, and Genetic Testing (BRCA) • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory committee on Immunization Practices (ACIP) schedule • Obesity screening/counseling • Healthy diet • Physical activity counseling See **Vision services (testing, treatment, and supplies)**, for annual routine eye exam benefits.	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Well woman care; based on current recommendations such as: • Cervical cancer screening (Pap smear) • Human papillomavirus (HPV) testing • Osteoporosis screening • Breast Cancer Screening • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling - Contraceptive drugs (Contraceptive drugs purchased at a non-Plan pharmacy are not covered, except emergencies) - Surgically implanted contraceptives - Injectable contraceptive drugs (such as Depo Provera) - Intrauterine devices (IUD's) - Diaphragms • Screening and counseling for interpersonal and domestic violence • Routine prenatal care • Female voluntary sterilization Preventive services required to be covered by group health plans at no cost share by federal health care reform legislation (the Affordable Care Act and implementing regulations).	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Notes: • Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. • A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at:	

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible…
Preventive care, adult (cont.)	**Standard Option**
www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services: www.healthcare.gov/preventive-care-women/ **For additional information:** www.Healthfinder.gov/myhealthfinder/default.aspx	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending camp, athletic exams or travel.*	*All Charges*
Preventive care, children	**Standard Option**
• Well-child visits, examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics • Initial exam of a newborn child covered under a family enrollment • Screening examination of premature infants for Retinopathy of prematurity • Routine circumcision from birth to one month old Preventive services required to be covered by group health plans at no cost share by federal health care reform legislation (the Affordable Care Act and implementing regulations)	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Notes: • Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. • A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS:www.healthcare.gov/preventive-care-benefits/ CDC:www.cdc.gov/vaccines/schedules/index.html For additional information: www.healthfinder.gov/myhealthfinder/default.aspx	

Preventive care, children - continued on next page

Benefit Description	You pay After the calendar year deductible…
Preventive care, children (cont.)	**Standard Option**
For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org/Pages/default.aspx	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending camp, athletic exams or travel.*	*All Charges*
Maternity care	**Standard Option**
Complete maternity (obstetrical) care by a physician, certified nurse midwife, or licensed midwife for: • Prenatal care (see *Preventive care, adult*) • Screening for gestational diabetes for pregnant women after 24 weeks • Delivery (including home births) • Postnatal care Breastfeeding support, supplies and counseling for each birth. Notes: Here are some things to keep in mind: • When seen in an emergency room for any reason, the **Emergency services/accidents** benefit cost-share will apply. • You do not need to preauthorize your vaginal delivery; see Section 3 for other information. • 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. Surgical benefits, not maternity benefits, apply to medically necessary circumcision. See Section 5(b), for circumcision benefits. We cover routine circumcision under Preventive care, children • When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. • Dependent child – pregnancy, delivery, and care of newborn during mother's hospital stay is covered. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital/birthing center costs, see Section 5(c) and Surgical benefits Section 5(b).	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Maternity care (cont.)	**Standard Option**
Not covered: • *Care of a dependent child's newborn once the mother is discharged from the hospital unless the newborn is determined to be your dependent by your personnel office.*	*All Charges*
Family planning	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary male sterilization (See Section 5(b), *Surgical procedures*)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Voluntary female sterilization (see *Preventive care, adult*) • Contraceptive methods and counseling (see *Preventive care*) - Surgically implanted contraceptives - Injectable contraceptive drugs (such as Depo Provera) - Intrauterine devices (IUDs) - Diaphragms	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization*	*All Charges*
Infertility services	**Standard Option**
Diagnosis & treatment of infertility such as: • Artificial insemination (AI): - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	In-network: 50% of Plan allowance Out-of-network: 50% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Allergy care	**Standard Option**
• Testing and treatment • Allergy injections	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Allergy serum	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between the Plan's allowed amount and the billed charges (No deductible)
Not covered: • *Provocative food testing and sublingual allergy desensitization.*	*All Charges*
Treatment therapies	**Standard Option**
• Chemotherapy and radiation therapy – some types of chemotherapy require preauthorization. Your physician should call Member Services toll-free at 888-901-4636 prior to you receiving therapy. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Section 5(b), *Organ/tissue transplants.* • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy in a medical office or outpatient hospital facility • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit and requires preauthorization. Note: We only cover GHT when we preauthorize the treatment. Your physician must obtain preauthorization before you begin treatment. See *Other services* under *You need prior Plan approval for certain services.*	In-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
• Intravenous (IV)/infusion therapy - Associated infused medications	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Intravenous (IV)/Infusion Therapy at home	Nothing (No deductible)
• Enteral nutritional therapy when necessary due to malabsorption and an eosinophilic gastrointestinal disorder, including equipment and supplies • Total parenteral nutritional therapy and supplies necessary for its administration	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	**Standard Option**
	Equipment and supplies are covered under Durable medical equipment (DME)
• Applies Behavioral Analysis (ABA) Therapy	Covered under Mental health and substance misuse disorder benefits Section 5(e)
Neurodevelopmental therapies	**Standard Option**
Coverage under this benefit for the restoration and improvement of function in a neurodevelopmentally disabled individual includes: • Inpatient and outpatient physical, speech and occupational therapy; and • Ongoing maintenance care in cases where significant deterioration of the child's condition would occur without the care All therapy treatments must be performed by a physician, registered physical therapist (PT), ASHA-certified speech therapist or an occupational therapist certified by the American Occupational Therapy Association. Coverage under this benefit does not duplicate coverage for therapy services provided under any other benefit of this Plan.	In-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Physical and occupational therapies	**Standard Option**
Up to 60 combined visits for rehabilitative or habilitative care per condition per calendar year for physical, occupational and speech therapy. This limit does not apply to rehabilitative or habilitative care for the treatment of mental health conditions. Services must be provided by qualified physical, occupational, or speech therapists. Notes: • Outpatient therapies that are provided in a rehabilitation unit that is part of an acute-care hospital, a stand-alone rehabilitation hospital, or an extended care/skilled nursing facility apply toward the maximum 60 combined visits per condition. See *Speech therapy,* and *Home health services.* • For inpatient therapy benefit, see Section 5(c).	In-network: $25 copayment per primary care visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Cardiac rehabilitation is provided, without visit limitations, following procedures such as: • Heart transplant • Bypass surgery • Myocardial infarction • Heart valve repair/replacement • Combined heart-lung transplant; • Angioplasty • Ischemic heart disease/coronary artery disease	In-network: $25 copayment per primary care visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies (cont.)	**Standard Option**
• Stable angina pectoris	In-network: $25 copayment per primary care visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Reflexology* • *Rolfing*	*All Charges*
Speech therapy	**Standard Option**
Up to 60 combined visits for rehabilitative or habilitative care per condition per calendar year for physical, occupational, massage and speech therapy. This limit does not apply to rehabilitative or habilitative care for the treatment of mental health conditions. Services must be provided by qualified speech therapists. Notes: • Outpatient therapy services that are provided in a rehabilitation unit that is part of an acute-care hospital, a stand-alone rehabilitation hospital, or an extended care/skilled nursing facility apply toward the maximum 60 combined visits per condition. • For inpatient therapy benefit, see Section 5(c).	In-network: $25 copayment per primary care visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Hearing services (testing, treatment, and supplies)	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see *Preventive care, children.*	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) Note: For benefits for these devices, see *Orthopedic and prosthetic devices.*	
Not covered: • *Hearing services that are not shown as covered*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Vision services (testing, treatment, and supplies)	**Standard Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Diagnostic eye exams provided by an optometrist or ophthalmologist to determine the need for vision correction. For routine screening eye exam benefit see *Preventive care, adult* and *Preventive care, children.*	In-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment (per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Annual routine eye exam for adults.	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Eyeglasses or contact lenses, except as related to accidental ocular injury or intraocular surgery* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All Charges*
Foot care	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See *Orthopedic and prosthetic devices*, for information on podiatric shoe inserts.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
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*

Benefit Description	You pay After the calendar year deductible…
Diabetic education, equipment and supplies	**Standard Option**
• Health Education and training - Nutritional guidance	In-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
• Medical Equipment - Dialysis equipment - Insulin pumps - Insulin infusion devices - Glucometers - Medically necessary orthopedic shoes and inserts • Supplies other than those covered under *Prescription drug benefits* such as: - Orthopedic and corrective shoes - Arch supports - Foot orthotics - Heel pads and heel cups - Elastic stockings, support hose - Prosthetic replacements	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Orthopedic and prosthetic devices	**Standard Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • External hearing aids and testing to fit them when prescribed by a qualified provider; benefit is limited to $1,000 for one hearing aid per ear which applies every year for children through age 17 and every two (2) years for adults • Osseointegrated implants/bone anchored hearing aids (BAHA); preauthorization is required. Please refer to the preauthorization information provided in Section 3. • Cochlear implants - requires preauthorization • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	**Standard Option**
Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical and anesthesia services*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services*. Note: Orthopedic and prosthetic devices must be obtained from a Medicare certified provider. Purchases made through the Internet generally do not meet this requirement and are not covered under this Plan. If you have questions about a provider you are considering, please contact us before obtaining the device(s).	
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered (except for externally worn breast prostheses and surgical bras)* • *Devices and supplies purchased through the Internet*	*All Charges*
Durable medical equipment (DME)	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Listed below are some of the items that are covered. The list is not all inclusive. For more details please contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. • Oxygen • Hospital beds • Wheelchairs • Crutches • Walkers • Motorized wheelchairs • Audible prescription reading device • Speech generating device	In-network:20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Note: DME must be obtained from a Medicare certified provider. Purchases made through the Internet generally do not meet this requirement and are not covered under this Plan. If you have questions about a provider you are considering, please contact us before obtaining the equipment.	
Not covered: • *Exercise equipment such as Nordic Track and/or exercise bicycles*	*All Charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	**Standard Option**
• *Equipment which is primarily used for non-medical purposes such as hot tubs and massage pillows* • *Convenience items* • *DME purchased through the Internet* • *Wigs and hair prostheses*	*All Charges*
Home health services	**Standard Option**
• Home health care ordered by a physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), master of social work (M.S.W.), or home health aide. Up to two hours per visit. • Services include oxygen therapy, intravenous therapy and assistance with medications. IV therapy supplies and medications are covered separately under the *Treatment therapies* benefit. Oxygen is covered separately under the *Durable medical equipment (DME)* benefit. Note: These services require preauthorization. Please refer to the preauthorization information shown in Section 3. Note: Therapy (physical, occupational, speech) received in your home is paid under the *Physical and occupational therapies* benefit and applies towards your therapy maximum of 60 visits per condition. See *Physical and occupational therapies.*	In-network: 20% of Plan allowance per visit Out-of-network: 40% of Plan allowance per visit and any difference between our allowance and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All Charges*
Chiropractic	**Standard Option**
• Up to 20 treatments per calendar year for manipulation of the spine and extremities	In-network: $25 copayment per primary care treatment or $35 copayment per specialty care treatment (no deductible) Out-of-network: $25 copayment per primary care treatment or $35 copayment per specialty care treatment, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Not covered: • *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Alternative treatments	**Standard Option**
• Massage therapy - up to 20 treatments per calendar year when treatment prescribed by a qualified provider and received from a licensed massage therapist • Acupuncture – up to 20 treatments per calendar year when treatment is received from a licensed provider for: - anesthesia - pain relief - substance misuse disorder - unlimited • Naturopathic services	In-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our Plan allowance and the billed amount (no deductible)
Not covered: • *Herbs prescribed by an East Asian Medicine Practitioner (acupuncturist) or naturopath* • *Hypnotherapy* • *Biofeedback* • *Reflexology* • *Rolfing*	*All Charges*
Educational classes and programs	**Standard Option**
Coverage is provided for: • Tobacco Cessation when participating in the Quit For Life® program. You will receive up to two (2) quit attempts per year and a minimum of four (4) counseling sessions that include individual, group, and telephone counseling, along with physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Call 866-784-8454 toll-free or visit the Quit For Life® website at www.quitnow.net for information on how to enroll.	Nothing for two quit attempts per calendar year through the Quit For Life® program. Nothing for physician prescribed over-the-counter and prescription drugs authorized by the Quit For Life® program and approved by the FDA to treat tobacco dependence. (No deductible)
• Outpatient nutritional guidance counseling services by a certified dietitian or certified nutritionist for conditions such as: - Cancer - Endocrine conditions - Swallowing conditions after stroke - Hyperlipidemia - Colitis - Coronary artery disease - Dysphagia - Gastritis - Inactive colon - Anorexia - Bulimia - Short bowel syndrome (post surgery)	In-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our Plan allowance and the billed amount (no deductible)

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible…
Educational classes and programs (cont.)	**Standard Option**
- Food allergies or intolerances - Obesity	In-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care office visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our Plan allowance and the billed amount (no deductible)
Not covered: • *Over-the-counter drugs, except for physician prescribed tobacco cessation medications received through the Quit For Life® program and approved by the FDA for treatment of tobacco dependence* • *Weight loss medications*	*All Charges*
Sleep disorders	**Standard Option**
Coverage under this benefit is limited to sleep studies, including provider services, appropriate durable medical equipment, and surgical treatments. No other benefits for the purposes of studying, monitoring and/or treating sleep disorders, other than as described below, is provided. **Sleep studies** – Coverage for sleep studies includes: • Polysomnographs • Multiple sleep latency tests • Continuous positive airway pressure (CPAP) studies • Related durable medical equipment and supplies, including CPAP machines • The condition giving rise to the sleep disorder (such as narcolepsy or sleep apnea) must be diagnosed by your provider. Preauthorization of sleep studies is not required; however, you must be referred to the sleep studies program by your provider.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Any service not listed above for the purpose of studying, monitoring and/or treating sleep disorders.*	*All Charges*
Temporomandibular joint (TMJ) disorders	**Standard Option**
Treatment of TMJ, includes surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Services primarily for cosmetic purposes* • *Related dental work*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Phenylketonuria (PKU) formulas	**Standard Option**
Special dietary formulas designed for use by those diagnosed with phenylketonuria.	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically
- The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to all benefits in this
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center,).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 and contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 to be sure which services

require preauthorization and identify which surgeries require preauthorization.

For non-Plan provider benefit see Section 5(i), *Point of Service (POS) benefits*, page 89.

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by thesurgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and prosthetic devices*, for device coverage information. Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Circumcision as medically necessary • Voluntary male sterilization (For female sterilization, See *Preventive care, adult*) • Transgender reassignment surgery	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**Standard Option**
- For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, and placement of testicular and erectile prosthesis - For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, labiaplasty • Treatment of burns • Surgical treatment (bariatric surgery) and all services associated with the surgical treatment of morbid obesity. Note: The surgical candidate must be at least 18 years or older, have no other health conditions with a Body Mass Index (BMI) of 40 or greater, or have at least one complicating medical condition with a BMI of 35 or greater. All inpatient and outpatient surgical treatment for morbid obesity must be preauthorized and performed through a bariatric surgery Center of Excellence. See *Other services* under *You need prior Plan approval for certain services*.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Foot care)* • *Weight loss medications* • *Services for the promotion, prevention, or other treatment of hair loss or hair grow* • *Cosmetic surgery, any surgery procedure (or any portion of the procedure) performed primarily to improve physical appearance through change in bodily form* • *Facial feminization and breast augmentation for the treatment of gender dysphoria* • *Services not listed above as covered*	*All Charges*
Reconstructive surgery	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as:	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	**Standard Option**
- Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedema - Breast prostheses and surgical bras and replacements (see Section 5(a), *Orthopedic and prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
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*
Oral and maxillofacial surgery	**Standard Option**
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; and • Other surgical procedures that do not involve the teeth or their supporting structures.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All Charges*
Organ/tissue transplants	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services.* • 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	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**Standard Option**
• Kidney • Kidney/pancreas • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in 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)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**Standard Option**
- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors - Waldenstrom's macroglobulinemia	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Mini-transplants performed in a clinical setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**Standard Option**
- Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, 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 non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinic trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**Standard Option**
- Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MPDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphomas (Mantel Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Breast cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**Standard Option**
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
National Transplant Program (NTP)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Notes: • *We cover related medical and hospital expenses of the donor when we cover the recipient.* • *We cover donor screening tests and donor search expenses for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.*	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Any transplant not specifically listed as a covered benefit*	*All Charges*
Sleep Disorders	**Standard Option**
Surgical treatment – Coverage for the medically necessary surgical treatment of diagnosed sleep disorders is covered under this benefit. Preauthorization of surgical procedures for the treatment of sleep disorders is required. See *Other services* under *You need prior Plan approval for certain services*. Surgical treatment includes all professional and facility fees related to the surgical treatment including pre- and post-operative care and complications.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Anesthesia	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

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
- The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) and (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR HOSPITAL** Please refer to Section 3 and contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 to be sure which services require preauthorization.

For non-Plan provider benefit see Section 5(i), *Point of Service (POS) benefits*, page 89.

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Note: Included under this benefit are admissions for inpatient physical, occupational, and speech therapies provided in a rehabilitation unit that is part of an acute-care hospital or stand-alone rehabilitation hospital. Note: Admission to a rehabilitation unit that is part of an acute-care hospital is considered a separate hospital stay, whether or not you were discharged from the hospital. Other hospital services and supplies, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood products, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference our allowance and the billed amount

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital (cont.)	**Standard Option**
• Anesthetics, including nurse anesthetist services • Take-home items (except medications) • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Private nursing care	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference our allowance and the billed amount
Maternity delivery charges in a hospital or birthing center.	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Take home medications*	*All Charges*
Outpatient hospital or ambulatory surgical center	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood products, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Telemedicine services provided by the use of real time interactive audio and video communication or time delayed transmission of medical information between the patient at the originating site and a provider at another location for diagnosis, consultation, or treatment. Services must be provided by a Washington state licensed physician. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental, physical impairment. We do not cover the dental procedures listed under Section 5(g), *Dental benefits*.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Take home medications* • *Audio-only, telephone, fax and e-mail communications*	*All Charges*

Benefit Description	You pay After the calendar year deductible...
Extended care benefits/Skilled nursing care facility benefits	**Standard Option**
When appropriate, as determined by a doctor and approved by us, we cover full-time skilled nursing care with no dollar or day limit. Intensive physical and occupational therapies in a skilled nursing facility apply toward the maximum 60 combined visits per condition. Extended care benefits require preauthorization by our medical director.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care*	*All Charges*
Hospice care	**Standard Option**
Supportive and palliative care for a terminally ill member is covered when services are provided under the direction of a doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less. Services include: • Medical care • Family counseling • Inpatient hospice benefits are available only when services are preauthorized and determined necessary to: - Control pain and manage the patient's symptoms; or - Provide an interval of relief (respite) to the family not to exceed seven (7) consecutive days; each respite care admission must be preauthorized and separated by at least 21 days.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Independent nursing, homemaker services*	*All Charges*
Ambulance	**Standard Option**
Coverage for ambulance services includes: • Ground transportation • Air transportation Air ambulance transportation is subject to review and approval by us. In cases where the patient's condition does not warrant air transportation, coverage will be based on the benefit for ground transportation. Note: If you are hospitalized in a non-Plan facility and Plan doctors believe care can be provided in a Plan hospital, you may ask to be transferred to a Plan provider when medically feasible with any ambulance charges covered in full.	20% of Plan allowance
Not covered: • *The use of any type of ambulance transportation for personal convenience.*	*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 calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9*, Coordinating benefits with Medicare and other coverage.*

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room.

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

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

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

Follow-up care received from non-Plan providers and/or at a non-Plan facility when the care could be received from a Plan provider and/or at a Plan facility, will be covered at the Point of Service (POS) benefit level. See Section 5(i), *Point of Service (POS) benefits*, page 72.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$25 copayment per primary care visit or $35 copayment per specialty care visit (no deductible)
• Emergency care as an outpatient or inpatient at a hospital, including doctor's services Note: If the emergency results in admission to a hospital, inpatient services are subject to the hospital admission coinsurance of 20% and the emergency care copay is waived.	$150 copayment
Not covered: • *Elective care or non-emergency care*	*All Charges*
Emergency outside our service area	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$25 copayment per primary care visit or $35 copayment per specialty care visit (no deductible)
• Emergency care as an outpatient or inpatient at a hospital, including doctor's services Note: If the emergency results in admission to a hospital, inpatient services are subject to the hospital admission coinsurance of 20% and the emergency care copay is waived.	$150 copayment
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All Charges*
Ambulance	**Standard Option**
Professional ambulance service when medically appropriate. • Ground transportation • Air transportation In cases where the patient's condition does not warrant air transportation, coverage will be based on the benefit for ground transportation. Note: If you are hospitalized in a non-Plan facility and Plan doctors believe care can be provided in a Plan hospital, you may ask to transferred to a Plan provider when medically feasible with any ambulance charges covered in full. See Section 5(c), for non-emergency service.	20% of Plan allowance
Not covered: • *The use of any type of ambulance transportation for personal convenience.*	*All Charges*

Section 5(e). Mental health and substance misuse 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.
- The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.
- **YOU MUST GET PREAUTHORIZATION FOR INPATIENT SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
- All inpatient stays must be preauthorized by the Plan. You or your mental health or substance misuse disorder treatment provider must obtain preauthorization by calling 800-223-6114 before services are provided. If preauthorization is not obtained, a retro-review may be done to determine if the services are covered and if they were medically necessary. Services that are not preauthorized will be reduced by 20%. Please see Section 3, "What happens when you don't follow the precertification rules."

We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

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

- 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.
- **For non-Plan provider benefit see Section 5(i), *Point of Service (POS) benefits*, page 72.**

Benefit Description	You pay After the calendar year deductible…
Professional services	**Standard Option**
We cover professional services by licensed professional mental health and substance misuse disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Outpatient diagnostic tests provided and billed by a licensed mental health and substance misuse disorder treatment practitioner • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy)	In-network: $25 copayment per individual visit (no deductible) Nothing for group therapy (No deductible)

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Professional services (cont.)	**Standard Option**
• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug misuse disorder, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In-network: $25 copayment per individual visit (no deductible) Nothing for group therapy (No deductible) Out-of-network: $25 copayment per individual visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible) Nothing for group therapy (No deductible)
Applied Behavioral Analysis (ABA) therapy - limited to outpatient treatment of an autism spectrum disorder as diagnosed and prescribed by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnosis and treatment of autism. Documented diagnostic assessments, individualized treatment plans and progress evaluations are required.	In-network: $25 copayment per individual visit (no deductible) Nothing for group therapy (No deductible) Out-of-network: $25 copayment per individual visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible) Nothing for group therapy (No deductible)
Diagnostics	**Standard Option**
• 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	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Inpatient hospital or other covered facility	**Standard Option**
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 • Professional services of physicians	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Outpatient hospital or other covered facility	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility. • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	In-Network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible…
Physical, Occupational and Speech Therapies	**Standard Option**
Services must be provided by qualified physical, occupational, or speech therapists.	In-network: $25 copayment per primary care visit or $35 copayment per specialty care office visit (no deductible) Out-of-network: $25 copayment per primary care visit or $35 copayment per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Not Covered	**Standard Option**
• *Services that, upon review, are determined to be inappropriate to treat your condition or are Plan exclusions.* • *Long-term rehabilitative therapy* • *Exercise programs*	*All Charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart on page 66.
- 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.
- Members must make sure their physicians 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.
- There is no calendar year deductible for this benefit.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

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

- **Who can write your prescription.** A physician, podiatrist, advanced registered nurse practitioner (ARNP), physician assistant (PA), midwife, or dentist who is licensed and provided with prescription authority from the jurisdiction of their practice must prescribe your medication.

Note: Some drugs require prior authorization and may be limited to a specific quantity or day supply (see Section 3, **Other services**, regarding prior approval).

- **Where you can obtain them.** You must fill the prescription at a Plan retail pharmacy or through a Plan mail order program, except for emergencies. If you have any questions regarding your pharmacy benefit, please call Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711.
- **Mail Order Program.** Covered prescription drugs are available through the mail order program. Prescriptions ordered through this program are subject to the same copayments, guidelines, and limitations set forth above. Mail order issues up to a 90-day supply per fill. To begin using mail order, or to transfer an existing prescription from a retail pharmacy, ask your prescriber to send the prescription directly to the mail order pharmacy:

  Kaiser Permanente
  Mail Order Pharmacy
  P.O. Box 34383
  Seattle, WA 98124-1383

  Phone: 1-800-245-7979
  Fax: 206-901-4443

- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply per fill, except for certain drugs, which may be dispensed on a 90-day supply basis with two (2) copayments. For prescribed hormonal contraceptives, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program.If a drug is a Tier 4 or 5 drug, you will pay the applicable coinsurance. Refills for any prescription drug cannot be obtained until at least 75% of the drug has been used. Drugs designated as specialty may be covered for up to a 30-day supply per fill. If you have a new prescription for a chronic condition, you may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity.
- **A generic equivalent will be dispensed if it is available.** If your physician believes that a name brand product is medically necessary, or if there is no generic equivalent available, your physician may prescribe a name brand drug. If you elect to purchase a name brand instead of the generic equivalent you are responsible for paying the difference in cost in addition to the prescription drug cost share.

Plan members called to active military duty (or members in a time of national emergency) who need to obtain prescribed medications should call Member Services toll-free at 888-901-4636.

We have an open Drug Formulary. Drug Formulary (approved drug list) is defined as a list of preferred pharmaceutical products the Pharmacy tier" categories:

- Tier 1 generally includes generic drugs, but may include some brand formulary or preferred brands. Usually represents the lowest copays.
- Tier 2 generally includes brand formulary and preferred brand drugs, but may include some generics and brands not included in Tier 1. Usually represents brand or middle-range copays.
- Tier 3 may include all other covered drugs not on tiers 1 and 2 (i.e., non-formulary or non-preferred).
- Tier 4 includes preferred specialty drugs.
- Tier 5 includes non-preferred specialty drugs.

Because of their lower cost to you, we recommend that you ask your provider to prescribe preferred drugs as the first choice of therapy. To order a Drug Formulary, call us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. You may also access the Drug Formulary on our website at www.kp.org/wa/fehb-options.

Preferred drugs are branded, single source or multi-source agents, or generic drugs that are determined to be preferred by us.

Non-preferred drugs are branded, single source or multi-source agents, or generic drugs that are determined to be non-preferred by us.

Note: The Drug Formulary is continually reviewed and revised. We reserve the right to update this list at any time. **For the most up-to-date information about our Drug Formulary, visit our website at www.kp.org/wa/fehb-options.**

- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Generic drugs must contain the same active ingredient and must be equivalent in strength and dosage to the original name brand product. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic drug costs you – and us – less than a name brand drug.
- **When you do have to file a claim.** When you use a Plan pharmacy, you will not be responsible for submitting a claim form to the Plan. In the event of an accidental injury or medical emergency, you may utilize the services of a non-Plan pharmacy. For reimbursement of pharmacy claims, please submit an itemized claim form with the following information:
  - Member's name and ID#
  - Drug name, quantity, prescription number
  - Cost of drug and amount you paid
  - NDC number
  - Drug strength
  - Pharmacy name
  - Pharmacy address
  - Pharmacy NABP number

Submit your request for reimbursement to:

Member Claims
P.O. Box 34585
Seattle, WA 98124-1585

- **For additional information** on your pharmacy benefits, call Member Services toll-free at 888-901-4636.
- **Specialty medications.** Certain medications must be ordered only through our specialty drug pharmacy program. Your physician must obtain preauthorization for these medications. For a list of specialty drugs, please go to Drug Lists on our website at www.kp.org/wa/fehb-options or call Member Services toll-free at 888-901-4636 prior to receiving services.

Benefit Description	You pay
Covered medications and supplies	**Standard Option**
We cover the following medications and supplies prescribed by a physician and obtained from a Plan retail pharmacy or through the mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction limited to eight (8) pills per prescription per month • Preauthorized compounded drugs • Hormone therapy	**Tier 1** $20 per prescription/refill $40 per 90-day supply **Tier 2 – Preferred** $40 per prescription/refill $80 per 90-day supply **Tier 3 – Non-Preferred** $60 per prescription/refill $120 per 90-day supply **Tier 4 – Preferred Specialty** 25% up to a maximum out of pocket of $200 per 30-day supply **Tier 5 – Non-Preferred Specialty** 35% up to a maximum out of pocket of $300 per 30-day supply
Women's contraceptive drugs and devices (see *Preventive care, adult*) Note: Over-the-counter contraceptive drugs and devices, including emergency contraceptives, approved by the FDA require a written prescription by an approved provider. Contraceptive drugs purchased at a non-Plan pharmacy are not covered, except emergencies.	Nothing (No deductible)
Mail Order Drug Program • Prescription medications mailed to your home by the Kaiser Permanente mail order pharmacy (mail order issues up to a 90-day supply per fill)	**Tier 1** $20 per prescription/refill $40 per 90-day supply **Tier 2 – Preferred** $40 per prescription/refill $80 per 90-day supply **Tier 3 – Non-Preferred** $60 per prescription/refill $120 per 90-day supply Mail order not available for specialty drugs
Limited Benefits • Drugs to aid in tobacco cessation when prescribed and dispensed as part of the Plan's tobacco cessation program • Over-the-counter tobacco cessation drugs when obtained through the Kaiser Permanente mail order pharmacy and plan retail pharmacy	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes*	*All Charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
• *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except treatment of phenylketonuria (PKU) as described elsewhere in this brochure* • *Non-prescription medicines, except certain over-the-counter substances approved by the Plan* • *Medical supplies such as dressings and antiseptics* • *Fertility drugs* • *Drugs to enhance athletic performance* • *Drugs prescribed to treat any non-covered service* • *Drugs obtained at a non-Plan pharmacy, except for emergencies* • *Compounded drugs for hormone replacement therapy* • *Drugs that are not medically necessary according to accepted medical, dental, or psychiatric practice as determined by the Plan* • *Lost or stolen medications* • *Non-self administered medications (e.g., intramuscular, intravenous, intrathecal)* • *Weight loss medications*	*All Charges*
Note: Over-the-counter and prescription drugs authorized by the Quit For Life® program and approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit (see Educational classes and programs).	
Preventive Care Medications	**Standard Option**
The following are covered: • Aspirin to reduce the risk of heart attack • Oral flouride for children to reduce the risk of tooth decay • Folic acid for women to reduce the risk of birth defects • Liquid iron supplements for children age 0-1 year • Vitamin D for adults to reduce the risk of falls • Medications to reduce the risk of breast cancer • Statins for adults at risk of cardiovascular disease Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network 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

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 Medicare and other coverage*.
- Only those procedures that are part of a routine/preventive dental exam are covered.
- We cover hospitalization for dental procedures only when a non-dental, physical impairment exists, which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c), for inpatient hospital benefits.
- The dental procedures listed below are not all-inclusive and are subject to change. Please call us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 for additions/changes to the list of covered American Dental Association (ADA) codes.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefit Description	You Pay After the calendar year deductible . . .
Accidental injury benefit	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. Sound natural teeth are those that do not have any restoration. (See Section 10, *Definitions of terms we use in this brochure*.) The need for these services must result from an accidental injury (not biting or chewing). All services must be performed and completed within 12 months of the date of injury.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Dental benefits	We pay scheduled allowance (you pay all excess charges)	
Dental Services	**Codes**	**Standard Option**
PREVENTIVE DENTAL CARE **(no deductible)** • **Diagnostic**		
X-rays		
Intraoral - periapical first film	D0220	$20.00
Intraoral – periapical each additional film	D0230	$19.00
Intraoral – occlusal film	D0240	$41.00
Bitewing X-rays – twice per calendar year		
Bitewing – single film	D0270	$20.00
Bitewing – two films	D0272	$31.00
Bitewing – four films	D0274	$45.00

Dental Services - continued on next page

Dental benefits	We pay scheduled allowance (you pay all excess charges)	
Dental Services (cont.)	**Codes**	**Standard Option**
Full mouth or panorex X-rays - once every 3 calendar years		
Panoramic film	D0330	$77.00
Intraoral - complete series (including bitewings)	D0210	$95.00
Oral Exam		
Periodic oral exam – twice per calendar year	D0120	$41.00
Limited oral evaluation – problem focused	D0140	$58.00
Comprehensive oral evaluation	D0150	$57.00
Pulp vitality tests	D0460	$38.00
Prophylaxis (cleaning) – twice per calendar year		
Prophylaxis – through age 13	D1120	$51.00
Prophylaxis – after age 13	D1110	$88.00
Fluoride – twice per calendar year through age 17		
Topical application of fluoride (prophylaxis not included)	D1208	$32.00
Other Preventive Services		
Application of sealants for permanent molars and bicuspids only (with a 3 year limitation per surface) through age 13; sealant per tooth	D1351	$28.00
Space Maintenance (Passive Appliances)		
Space maintainer – fixed – unilateral	D1510	No benefit

Section 5(h). Wellness and other special features

Feature	Description
Flexible benefits option	In certain cases, Kaiser Permanente Washington Options Federal, at its sole discretion, may choose to authorize coverage for benefits or services that are not otherwise included as covered under this Plan. Such authorization is done on a case-by-case basis if a particular benefit or service is judged to be medically necessary, beneficial, and cost effective. However, our decision to authorize services in one instance does not commit us to cover the same or similar services for you in other instances or to cover the same or similar services in any other instance for any other enrollee. Our decision to authorize services does not constitute a waiver of our right to enforce the provisions, limitations, and exclusions of this Plan. 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 claim process (see Section 8).
Consulting Nurse Service	For urgent care information and after hours care 24 hours a day, 7 days a week, call toll free 800-297-6877
Services for deaf, hard of hearing, or speech impaired	We provide a TTY/text number at: 711. Sign language services are also available.
Travel benefit/services overseas	If you are on Temporary Duty Assignment or reside temporarily outside of Washington state you are covered for all of the benefits described in this brochure. You pay the applicable cost-share per visit for services. For non-urgent and non-emergent services you should receive care from a Plan provider; in Idaho, Oregon, Montana and Alaska, a Plan provider is a First Choice Health Network provider, and in all other states, a Plan provider is a First Health Network provider. Medications obtained at a participating pharmacy in connection with non-urgent, non-emergent services will also be covered. See also Section 1. *How we pay providers.* If you need assistance while anywhere in the world, call Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711.

	Filing Overseas Claims for Urgent or Emergent Care Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement**. To file a claim for covered urgent or emergent care received outside the United States, send a completed Overseas Claim Form and itemized bills to: Member Claims P.O. Box 34585 Seatle, WA 98124-1585 We will do the translation and currency conversion for you. You may obtain the Overseas Claim Form by calling Member Services toll-free at 888-901-4636 or from our website at www.kp.org/wa/fehb-options, Members/Forms and Information.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $350 per person ($700 per family).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

Facts about this Plan's POS option

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

What is covered

All services/treatments listed in this brochure as covered.

What is not covered

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

- Orthopedic and prosthetic devices/supplies and durable medical equipment (DME) purchased through the Internet.
- Expenses in excess of the Plan's allowable amount or benefit maximum (e.g., dental fee schedule amounts).
- The difference between the billed amount and the amount allowed by Kaiser Permanente Washington Options Federal.

Emergency benefits

Emergency care is always payable at the Plan provider level of benefit. Please see Section 5(d), *Emergency services/accidents*, page 60, for benefit details.

What you pay

When you **choose** to obtain services from a **non-Plan** provider or hospital:

- We will determine what our allowable amount would have been for a Plan provider*.
- We will apply your appropriate cost-sharing (i.e., deductible and/or copayment) to the allowed amount.
- You pay the non-Plan provider 40% of the allowed amount balance after you have paid your appropriate cost-sharing.
- The non-Plan provider may balance bill you for the difference between what we pay and the original charges.

***Note: If our allowed amount is more than what the non-Plan provider or hospital bills, we will base our payment on their billed amount.**

Section 5. High Deductible Health Plan Benefits

See page 17 for how our benefits changed this year and page 149 for a benefits summary.

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Summary of benefits for the HDHP of Kaiser Permanente Washington Options Federal - 2018 149

Section 5. High Deductible Health Plan Benefits Overview

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

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711; or visit our website at www.kp.org/wa/fehb-options.

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

Based on your eligibility, when you enroll in this HDHP, you can have either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) account. We automatically pass through a portion of your total health Plan premium to your HSA each month or credit an equal amount to your HRA.

The first year you enroll in this HDHP, funds will be prorated based on your enrollment effective date. If your enrollment is effective other than the first day of a month, your HSA funds (or HRA credit) will be prorated based on the first of the following month. **Before funding for either an HSA or HRA can occur, we must receive an HSA Eligibility Worksheet from you** (the worksheet is sent to you with your new member materials or is available on our website at www.kp.org/wa/fehb-options). If you are eligible for an HSA, in addition to the worksheet, you must complete the HSA enrollment process with HealthEquity®.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on pages 89 - 123. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

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

- **Preventive care**

  The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), well-child care, child and adult immunizations, and preventive dental care. These services, except for preventive dental, are covered at 100% if you use a network provider and the services are described in Section 5, page 85, *Preventive care*. ***You do not have to meet the deductible before using these services.***

  The Plan covers the *Quit For Life®* tobacco cessation program, obesity weight loss programs, and nutritional guidance under *Educational classes and programs*. Please see Section 5(a), page 99, for benefit details.

- **Traditional medical coverage**

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

  Covered services include:

  - Medical services and supplies provided by physicians and other health care professionals
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital and other facility services
  - Ambulance services
  - Emergency services/accidents
  - Mental health and substance misuse disorder benefits

- Prescription drug benefits
- Accidental dental injury benefits

- **Out-of-network services**

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

When you use non-Plan providers, your benefits are significantly less than if you use Plan providers. Kaiser Permanente Washington Options Federal will pay 60% of our allowed amount or the non-Plan provider's billed amount, whichever is less. In addition, it is your responsibility to pay the difference between any amounts billed by the non-Plan provider and the amount allowed by Kaiser Permanente Washington Options Federal. This is called "balance billing."

What is covered
All services/treatments listed in this brochure as covered under the HDHP, except preventive care, including preventive dental care.

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

- Expenses in excess of the Plan's allowable amount or benefit maximum (e.g., preventive dental care fee schedule amounts).
- The difference between the billed amount and the amount allowed by Kaiser Permanente Washington Options Federal.

Emergency benefits
Emergency care is always payable at the in-network benefit level. Please see Section 5(d), *Emergency services/accidents,* page 114, for benefit details.

- **Savings**

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 79 for more details).

Health Savings Accounts (HSAs)

By law, HSAs are available to members who:

- Are not enrolled in Medicare;
- Cannot be claimed as a dependent on someone else's tax return;
- Have not received VA (except for service connected disability) and/or Indian Health Services (IHS) benefits within the last three months; or
- Do not have other health insurance coverage other than another high deductible health plan.

In 2018, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $62.50 per month for a Self Only enrollment or $125 per month for a Self Plus One or Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $3,450 for an individual and $6,900 for a family. See maximum contribution information on page 80. You can use funds in your HSA to help pay your health Plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

NOTE: When you enroll in this HDHP, we will send you an HSA Eligibility Worksheet and instructions on how to enroll in an HSA with HealthEquity®. The worksheet is sent to you with your new member materials or is available on our website at www.kp.org/wa/fehb-options. The first year you enroll in this HDHP, funds will be prorated based on your enrollment effective date. If your enrollment is effective other than the first day of a month, your HSA funds will be prorated based on the first of the following month. Before funding for an HSA can occur, we must receive the HSA Eligibility Worksheet. In addition to the worksheet, you must complete the HSA enrollment process with HealthEquity®.

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

HSA features include:

- Your HSA is administered by HealthEquity®.
- Your contributions to the HSA are tax deductible.
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).
- Your HSA earns tax-free interest.
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses).
- Your unused HSA funds and interest accumulate from year to year.
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire.
- When you need them, your funds are available up to the actual HSA balance.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA (such as FSAFEDS offers – see *Section 11, Other Federal Programs*), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish a Health Reimbursement Arrangement (HRA) account for you.

Health Reimbursement Arrangements (HRA)

If you aren't eligible for an HSA, for example you are enrolled in Medicare or are covered on another health plan, we will establish an HRA for you instead. You must notify us that you are ineligible for an HSA by returning the HSA Eligibility Worksheet from your new member materials; the worksheet also is available on our website at www.kp.org/wa/fehb-options.

In 2018, we will give you an HRA credit of $750 per year for a Self Only enrollment and $1,500 per year for a Self Plus One or Self and Family enrollment (these amounts may be prorated the first year you are enrolled in this HDHP). You can use funds in your HRA to help pay your Plan deductible and/or for certain expenses that do not count toward the deductible.

HRA features include:

- Your HRA is administered by HealthEquity®.

- When you need them, your funds are available up to the actual HRA balance.

  NOTE: If your enrollment in this HDHP becomes effective other than the first day of a month, your HRA credit will be available to you the first of the following month.

- The tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP.
- Unused credit carries over from year to year.
- The HRA credit does not earn interest.
- The HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

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

  Your annual maximum for out-of-pocket expenses (deductibles, coinsurance, and copayments) for covered services is limited to $5,000 for Self Only enrollment or $5,000 per person for Self Plus One or Self and Family enrollment not to exceed a total out-of-pocket maximum of $10,000 (each applies separately for services received from Plan providers and non-Plan providers). However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4, *Your catastrophic protection out-of-pocket maximum*, for more details.

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

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

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA with HealthEquity®, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	The Plan will establish an HRA with HealthEquity®, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.).
Fees	Monthly administration fee charged by the fiduciary is paid by the Plan.	Monthly administration fee charged by the fiduciary is paid by the Plan.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision, or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA and/or Indian Health Services (IHS) benefits in the last three months • Complete and return the HSA Eligibility Worksheet to the Plan	You must: • Enroll in this HDHP • Complete and return the HSA Eligibility Worksheet to the Plan
Funding	If you are eligible for HSA contributions, a portion of your monthly health Plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i. e., Employee Express, MyPay, etc.). **NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, you will be eligible to receive the premium pass through contribution beginning the first of the following month.**	HRA contributions are a portion of your monthly health plan premium which is credited to your HRA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. **NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, funding for your HRA will be prorated based on the first of the following month.**
• **Self Only enrollment**	For 2018, a monthly premium pass through of $62.50 will be made by the HDHP directly into your HSA each month.	For 2018, a monthly premium pass through of $62.50 will be made by the HDHP directly into your HRA each month.
• **Self Plus One enrollment**	For 2018, a monthly premium pass through of $125 will be made by the HDHP directly into your HSA each month.	For 2018, a monthly premium pass through of $125 will be made by the HDHP directly into your HRA each month.

• **Self and Family enrollment**	For 2018, a monthly premium pass through of $125 will be made by the HDHP directly into your HSA each month.	For 2018, a monthly premium pass through of $125 will be made by the HDHP directly into your HRA each month.
Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of the HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,400 for an individual and $6,750 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP. HSAs earn tax-free interest (interest does not affect your annual maximum contribution). Catch-up contributions are discussed on page 83.	Your monthly premium pass through will be credited to your HRA each month. The HRA does not earn interest. **NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, funding for your HRA will be prorated based on the first of the following month.**
• **Self Only enrollment**	You may make an annual maximum contribution of $2,650 if your enrollment effective date is January 1.	You cannot contribute to the HRA.
• **Self Plus One enrollment**	You may make an annual maximum contribution of $5,250 if your enrollment effective date is January 1.	You cannot contribute to the HRA.

• **Self and Family enrollment**	You may make an annual maximum contribution of $5,250 if your enrollment effective date is January 1.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • HealthEquity® Visa® account • Online portal • Withdrawal form	You can access your HRA by the following methods: • HealthEquity® Visa® Card • Online portal • Withdrawal form
Distributions/withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse, or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds*, page 81, for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty; however, they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The Plan receives record of your enrollment. • The Plan sends you an HSA Eligibility Worksheet and instructions on how to enroll in an HSA with HealthEquity®. • You return the HSA Eligibility Worksheet to the Plan, confirming you meet the HSA eligibility requirements. • You enroll in an HSA with HealthEquity®.	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The Plan receives record of your enrollment. • The Plan sends you an HSA Eligibility Worksheet for you to complete. • You return the completed worksheet to the Plan, showing you are *not* eligible for an HSA. • The Plan forwards your enrollment information to HealthEquity® and establishes your HRA

Availability of funds (cont.)	• The Plan confirms your HSA enrollment with HealthEquity®. • The Plan initiates premium pass through contributions to your HSA. **NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, you will be eligible to receive funding for your HSA the first of the following month.**	Your monthly premium pass through will be credited to your HRA each month, beginning the first of the month following the Plan's receipt of the HSA Eligibility Worksheet. Accumulated funds will be made available to you to pay for qualified medical expenses and Medicare Part B premium. **NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, funding for your HRA will be prorated based on the first of the following month.**
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate, or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 79 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement, subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are tax deductible. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective date is after January 1st, or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

  Contact HealthEquity® toll-free at 866-346-5800 for more details.

- **Catch-up contributions**

  If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury website at www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx.

- **If you die**

  If you have not named beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.

- **Qualified expenses**

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

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

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

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

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

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount.

If you have an HRA

- **Why an HRA is established**

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

- **How an HRA differs**

  Please review the chart on page 79, which details the differences between an HRA and an HSA. The major differences are:

  - you cannot make contributions to an HRA,
  - funds are forfeited if you leave the HDHP,
  - an HRA does not earn interest,
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include 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.

  Contact HealthEquity® toll-free at 866-346-5800 for more details.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible.
- You must use Plan providers.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible,* page 89.

Benefit Description	You pay
Preventive care, adult	
• One annual routine physical • One annual routine eye exam	Nothing
Routine screenings, such as: • Abdominal aortic aneurysm one time screening by ultrasonography for men with a history of smoking • Complete Blood Count, one annually • A fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides) for adults • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening - Colonoscopy screening • Annual routine Prostate Specific Antigen (PSA) test for men • Annual routine mammogram for women • Adult routine immunizations endorsed by the Center for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule • Obesity screening/counseling • Healthy diet • Physical activity counseling	Nothing
Well woman care; based on current recommendations such as: • Cervical cancer screening (Pap smear) • Human papillomavirus (HPV) testing • Osteoporosis screening • Breast cancer screening (Breast Related Cancer Risk Assessment, Genetic Counseling, and Genetic Testing (BRCA)) • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling - Contraceptive drugs (Contraceptive drugs purchased at a non-Plan pharmacy are not covered, except emergencies) - Surgically implanted contraceptives - Injectable contraceptive drugs (such as Depo Provera) - Intrauterine devices (IUDs)	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
- Diaphragms • Screening and counseling for interpersonal and domestic violence • Routine prenatal care • Female voluntary sterilization Preventive services required to be covered by group health plans at no cost share by federal health care reform legislation (the Affordable Care Act and implementing regulations)	Nothing
Notes: • Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. • A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ **HHS**: www.healthcare.gov/preventive-care-benefits/ **CDC:**www.cdc.gov/vaccines/schedules/index.html **Women's preventive services:** www.healthcare.gov/preventive-care-women/ **For additional information:**www.Healthfinder.gov/myhealthfinder/default.aspx	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending camp, athletic exams or travel.* • *Preventive services received from a non-Plan provider*	*All Charges*
Preventive care, children	
• Well-child visits, examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics • Initial exam of a newborn child covered under a family enrollment • Screening examination of premature infants for Retinopathy of prematurity • Routine circumcision from birth to one month old Preventive services required to be covered by group health plans at no cost share by federal health care reform legislation (the Affordable Care Act and implementing regulations).	Nothing
Notes: • Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
• A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ **HHS**: www.healthcare.gov/preventive-care-benefits/ **CDC**: www.cdc.gov/vaccines/schedules/index.html For additional information: www.healthfinder.gov/myhealthfinder/default.aspx For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org/Pages/default.aspx	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending camp, athletic exams or travel.* • *Preventive services received from a non-Plan provider*	*All Charges*

Dental preventive care		
Dental Services	**Codes**	**We Pay Scheduled Allowance (you pay all excess charges)**
• **Diagnostic** **X-rays**		
Intraoral - periapical first film	D0220	$20.00
Intraoral - periapical each additional film	D0230	$19.00
Intraoral - occlusal film	D0240	$41.00
Bitewing X-rays - twice per calendar year		
Bitewing - single film	D0270	$20.00
Bitewing - two films	D0272	$31.00
Bitewing - four films	D0274	$45.00
Full mouth or panorex X-rays - once every 3 calendar years		
Panoramic film	D0330	$77.00
Intraoral - complete series (including bitewings)	D0210	$95.00
Oral exam		
Periodic oral exam - twice per calendar year	D0120	$41.00
Limited oral evaluation - problem focused	D0140	$58.00
Comprehensive oral evaluation	D0150	$57.00
Pulp vitality tests	D0460	$38.00
Prophylaxis (cleaning) - twice per calendar year		
Prophylaxis - through age 13	D1120	$51.00
Prophylaxis - after age 13	D1110	$88.00
Fluoride - twice per calendar year through age 17		

Dental Services - continued on next page

Dental preventive care		
Dental Services (cont.)	**Codes**	**We Pay Scheduled Allowance (you pay all excess charges)**
Topical application of fluoride (prophylaxis not included)	D1208	$32.00
Other Preventive Services		
Application of sealants for permanent molars and bicuspids only (with a 3 year limitation per surface) through age 13; sealant per tooth	D1351	$28.00
Not covered: • *Dental services not on our schedule allowance list*		*No benefit*

NOTE: The procedures and scheduled allowances listed in this brochure are intended as a summary of the most common procedures, not an exhaustive list. For questions regarding other specific procedures and scheduled allowances that fall under any of the preventive dental care procedures listed above, please call our Member Services department toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711.

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% (see page 85) and is not subject to the calendar year deductible.
- The deductible is $1,500 per person for Self Only enrollment or $1,500 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,000 (each applies separately for services received from Plan providers and non-Plan providers). The deductible applies to all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments, and deductibles total $5,000 per person up to $10,000 per family enrollment (each applies separately for services received from Plan providers and non-Plan providers) in any calendar year, you do not have to pay any more for covered services. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum or amounts in excess of the Plan allowance).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefit Description	You pay After the calendar year deductible…
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of $1,500 per person for Self Only enrollment or $1,500 per person for Self Plus One or Self and Family enrollment, not to exceed a total family deductible of $3,000 (each applies separately for services received from Plan providers and non-Plan providers).
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	**In-network:** After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket. **Out-of-network:** After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,500 for Self Only enrollment or $1,500 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,000 (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The deductible applies to most benefits in this Section, unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services	
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion • At a hospital - inpatient & outpatient visits • In a skilled nursing facility • At home	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Virtual care: Healthcare service provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (ex. home) with an in-network provider that is diagnostic and treatment focused. The Member is NOT located at a healthcare site.	In-network: Nothing Out-of-network: Not covered
Not Covered: • *Fax and e-mail communication* • *Virtual care from a non-Plan provider*	*All Charges*
Telehealth Services	
Telemedicine services provided by the use of real time interactive audio and video communication or time delayed transmission of medical information between the patient at the originating site and a provider at another location for diagnosis, consultation, or treatment. Services must be provided by a Washington state licensed physician.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not Covered: • *Audio-only, telephone, fax and e-mail communications*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	In-network: 20% of Plan allowance Out-of-network: Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care by a physician, certified nurse midwife, or licensed midwife for: • Prenatal care (see *Preventive care, adult*) • Delivery (including home births) • Postnatal care Notes: Here are some things to keep in mind: • When seen in an emergency room for any reason, the **Emergency services/accidents** benefit cost-share will apply. • You do not need to preauthorize your vaginal delivery; see Section 3 for other information. • 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 a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to medically necessary circumcision. See Section 5 (b), for circumcision benefits. We cover routine circumcision under Preventive care, children. • When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her 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. • Dependent child – pregnancy, delivery, and care of newborn during mother's hospital stay is covered. • Hospital services are covered under Section 5(c) and Surgical benefit under Section 5(b)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Maternity care (cont.)	
• Breastfeeding support, supplies and counseling for each birth • Screening for gestational diabetes for pregnant women after 24 weeks	In-network: Nothing (No deductible) Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Care of a dependent child's newborn once the mother is discharged from the hospital, unless the newborn is determined to be your dependent by your personnel office*	*All Charges*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary male sterilization (See Section 5(b), for surgical procedures) • Voluntary female sterilization (see *Preventive care, adult*) • Contraceptive methods and counseling (see *Preventive care, adult*) - Surgically implanted contraceptives - Injectable contraceptive drugs (such as Depo Provera) - Intrauterine devices (IUDs) - Diaphragms	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization*	*All Charges*
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination (AI): - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	In-network: 50% of Plan allowance Out-of-network: 50% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Allergy care	
• Testing and treatment • Allergy injections	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Allergy serum	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All Charges*
Treatment therapies	
• Chemotherapy and radiation therapy – some types of chemotherapy require preauthorization. Your physician should call Member Services toll-free at 888-901-4636 prior to you receiving therapy. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Section 5(b), *Organ/tissue transplants*. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV supplies and medications that are self-administered, antibiotic therapy, hydration, pain management and associated infused medications. • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit and requires preauthorization. Note: We only cover GHT when we preauthorize the treatment. Your physician must obtain preauthorization before you begin treatment. See *Other services* under *You need prior Plan approval for certain services*.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Enteral nutritional therapy when necessary due to malabsorption and an eosinophilic gastrointestinal disorder, including equipment and supplies • Total parenteral nutritional therapy and supplies necessary for its administration	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount Equipment and supplies are covered Durable medical equipment (DME)
• Applies Behavioral Analysis (ABA) Therapy	Covered under Mental health and substance misuse disorder benefits Section 5(e)

Benefit Description	You pay After the calendar year deductible…
Neurodevelopmental therapies	
Coverage under this benefit for the restoration and improvement of function in a neurodevelopmentally disabled individual includes: • inpatient and outpatient physical, speech and occupational therapy; and • ongoing maintenance care in cases where significant deterioration of the child's condition would occur without the care. All therapy treatments must be performed by a physician, registered physical therapist (PT), ASHA-certified speech therapist or an occupational therapist certified by the American Occupational Therapy Association. Coverage under this benefit does not duplicate coverage for therapy services provided under any other benefit of this Plan.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Physical and occupational therapies	
Up to 60 combined visits for rehabilitative or habilitative care per condition per calendar year for physical, occupational and speech therapy. Services must be provided by qualified physical, occupational or speech therapists. Notes: • Outpatient therapies that are provided in a rehabilitation unit that is part of an acute-care hospital, a stand-alone rehabilitation hospital, or an extended care/skilled nursing facility apply toward the maximum 60 combined visits per condition. See *Speech therapy* and *Home health services*. • For inpatient therapy benefit, see Section 5(c).	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Cardiac rehabilitation is provided, without visit limitations, following procedures such as: • Heart transplant; • Bypass surgery; • Myocardial infarction; • Heart valve repair/replacement; • Combined heart-lung transplant; • Angioplasty; • Ischemic heart disease/coronary artery disease; or • Stable angina pectoris	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Reflexology* • *Rolfing*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Speech therapy	
Up to 60 combined visits for rehabilitative or habilitative care per condition per calendar year for physical, occupational and speech therapy, except we cover rehabilitative or habilitative therapy with no limits for the treatment of mental health conditions. Services must be provided by qualified physical, occupational or speech therapists. Notes: • Outpatient therapy services that are provided in a rehabilitation unit that is part of an acute-care hospital, a stand-alone rehabilitation hospital, or an extended care/skilled nursing facility apply toward the maximum 60 combined visits per condition. • For inpatient therapy benefit, see Section 5(c)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Hearing services (testing, treatment, and supplies)	
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see *Preventive care, children.*	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) Note: For benefits for the devices, see *Orthopedic and prosthetic devices.*	
Not covered: • *Hearing services that are not shown as covered*	*All Charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Diagnostic eye exams provided by an optometrist or ophthalmologist to determine the need for vision correction. For routine screening eye exam benefits see *Preventive care, adult,* and *Preventive care, children.*	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses, except as related to accidental ocular injury or intraocular surgery* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
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*
Diabetic education, equipment and supplies	
• Health Education and Training - Nutritional guidance • Medical Equipment - Dialysis equipment - Insulin pumps - Insulin infusion devices - Glucometers - Medically necessary orthopedic shoes and inserts • Supplies other than those covered under *Prescription drug benefits* such as: - Orthopedic and corrective shoes - Arch supports - Foot orthotics - Heel pads and heel cups - Elastic stockings, support hose - Prosthetic replacements	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • External hearing aids and testing to fit them when prescribed by a qualified provider; benefit is limited to $1,000 for one hearing aid per ear which applies every year to children through age 17 and every two (2) years for adults	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	
• Osseointegrated implants/bone anchored hearing aids (BAHA); preauthorization is required. Please refer to the preauthorization information provided in Section 3. • Cochlear implants - requires preauthorization • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical and anesthesia services*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services*.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Note: Orthopedic and prosthetic devices must be obtained from a Medicare certified provider. Purchases made through the Internet generally do not meet this requirement and are not covered under this Plan. If you have questions about a provider you are considering, please contact us before obtaining the devices.	
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered (except for externally worn breast prostheses and surgical bras)* • *Devices and supplies purchased through the Internet*	*All Charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Listed below are some of the items that are covered. The list is not all inclusive. For more details please contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. • Oxygen • Hospital beds • Wheelchairs • Crutches • Walkers • Motorized wheelchairs • Audible prescription reading device • Speech generating device	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	
Note: DME must be obtained from a Medicare certified provider. Purchases made through the Internet generally do not meet this requirement and are not covered under this Plan. If you have questions about a provider you are considering, please contact us before obtaining the equipment.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Exercise equipment such as Nordic Track and/or exercise bicycles* • *Equipment which is primarily used for non-medical purposes such as hot tubs and massage pillows* • *Convenience items* • *DME purchased through the Internet* • *Wigs and hair prostheses*	*All Charges*
Home health services	
• Home health care ordered by a physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), master of social work (M.S.W.), or home health aide. Up to two hours per visit. • Services include oxygen therapy, intravenous therapy, and assistance with medications. IV therapy supplies and medications are covered separately under the *Treatment therapies* benefit. Oxygen is covered separately under the *Durable medical equipment (DME)* benefit. Note: These services require preauthorization. Please refer to the preauthorization information shown in Section 3. Note: Therapy (physical, occupational, speech) received in your home is paid under the *Physical and occupational therapies* benefit and applies towards your therapy maximum of 60 visits per condition. See *Physical and occupational therapies.*	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Chiropractic	
• Up to 20 treatments per calendar year for manipulations of the spine and extremities	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application*	*All Charges*
Alternative treatments	
• Massage therapy - up to 20 treatments per calendar year when treatment prescribed by a qualified provider and received from a licensed massage therapist • Acupuncture – up to 20 treatments per calendar year when treatment is received from a licensed provider for: - anesthesia - pain relief - substance misuse disorder - unlimited • Naturopathic services	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Herbs prescribed by an East Asian Medicine Practitioner (acupuncturist) or naturopath* • *Hypnotherapy* • *Biofeedback* • *Reflexology* • *Rolfing*	*All Charges.*
Educational classes and programs	
Coverage is provided for: • Tobacco Cessation when participating in the Quit For Life® program. You will receive up to two (2) quit attempts per year and a minimum of four (4) counseling sessions that include individual, group, and telephone counseling, along with physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Call 866-784-8454 toll-free or visit the Quit For Life® website at www.quitnow.net for information on how to enroll.	Nothing for two quit attempts per year through the Quit For Life® program. Nothing for physician prescribed over-the-counter and prescription drugs authorized by the Quit For Life® program and approved by the FDA to treat tobacco dependence. (No deductible)
• Outpatient nutritional guidance counseling services by a certified dietitian or certified nutritionist for conditions such as: - Cancer - Endocrine conditions - Swallowing conditions after stroke - Hyperlipidemia	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible…
Educational classes and programs (cont.)	
- Colitis - Coronary artery disease - Dysphagia - Gastritis - Inactive colon - Anorexia - Bulimia - Short bowel syndrome (post surgery) - Food allergies or intolerances - Obesity	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not Covered: • *Over-the-counter drugs, except for physician prescribed tobacco cessation medications received through the Quit For Life® program and approved by the FDA for treatment of tobacco dependence* • *Weight-loss medications*	*All Charges*
Sleep disorders	
Coverage under this benefit is limited to sleep studies, including provider services, appropriate durable medical equipment, and surgical treatments. No other benefits for the purposes of studying, monitoring and/or treating sleep disorders, other than as described below, is provided. **Sleep studies** - Coverage for sleep studies includes: • Polysomnographs • Multiple sleep latency tests • Continuous positive airway pressure (CPAP) studies • Related durable medical equipment and supplies, including CPAP machines The condition giving rise to the sleep disorder (such as narcolepsy or sleep apnea) must be diagnosed by your provider. Preauthorization of sleep studies is not required; however, you must be referred to the sleep studies program by your provider.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Any service not listed above for the purpose of studying, monitoring and/or treating sleep disorders.*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Temporomandibular joint (TMJ) disorders	
Treatment of TMJ, includes surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Services primarily for cosmetic purposes* • *Related dental work*	*All Charges*
Phenylketonuria (PKU) formulas	
Special dietary formulas designed for use by those diagnosed with phenylketonuria.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,500 for Self Only enrollment, $1,500 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,000 (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 and contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 to be sure which services and surgeries require preauthorization.

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	
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*) • Insertion of internal prosthetic devices (See Section 5(a), *Orthopedic and prosthetic devices*, for device coverage information.) Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Circumcision as medically necessary • Voluntary male sterilization (For female sterilization, see *Preventive care, adult.*) • Transgender reassignment surgery	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
- For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, and placement of testicular and erectile prosthesis - For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, labiaplasty • Treatment of burns • Surgical treatment (bariatric surgery) and all services associated with the surgical treatment of morbid obesity. Note: The surgical candidate must be at least 18 years or older, have no other health conditions with a Body Mass Index (BMI) of 40 or greater, or have at least one complicating medical condition with a BMI of 35 or greater. All inpatient and outpatient surgical treatment for morbid obesity must be preauthorized and performed through a bariatric surgery Center of Excellence. See *Other services* under *You need prior Plan approval for certain services.*	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Foot care)* • *Weight loss medications* • *Services for the promotion, prevention, or other treatment of hair loss or hair grow* • *Cosmetic surgery, any surgery procedure (or any portion of the procedure) performed primarily to improve physical appearance through change in bodily form* • *Facial feminization and breast augmentation for the treatment of gender dysphoria* • *Services not listed above as covered*	*All Charges*
Reconstructive surgery	
• 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. • All stages of breast reconstruction surgery following a mastectomy, such as:	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	
- surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedema - breast prostheses and surgical bras and replacements (see Section 5(a), *Orthopedic and prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
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*
Oral and maxillofacial surgery	
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; and • Other surgical procedures that do not involve the teeth or their supporting structures.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All Charges*
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services.* • 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	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Kidney • Kidney/pancreas • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in 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)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses below. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors - Waldenstrom's macroglobulinemia	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Mini-transplants performed in a clinical setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, 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 non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinic trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MPDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous transplants for - Advancec childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphomas (Mantel Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Breast cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
National Transplant Program (NTP)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Notes: • *We cover related medical and hospital expenses of the donor when we cover the recipient.* • *We cover donor screening tests and donor search expenses for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.*	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Any transplant not specifically listed as a covered benefit*	*All Charges*
Sleep disorders	
Surgical treatment – Coverage for the medically necessary surgical treatment of diagnosed sleep disorders is covered under this benefit. Preauthorization of surgical procedures for the treatment of sleep disorders is required. See *Other services* under *You need prior Plan approval for certain services*. Surgical treatment includes all professional and facility fees related to the surgical treatment including pre- and post-operative care and complications.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,500 for Self Only enrollment, $1,500 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,000 (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) and (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 and contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 to be sure which services require preauthorization.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Notes: • If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. • Included under this benefit are admissions for inpatient physical, occupational, and speech therapies provided in a rehabilitation unit that is part of an acute-care hospital or stand-alone rehabilitation hospital. • Admission to a rehabilitation unit that is part of an acute-care hospital is considered a separate hospital stay, whether or not you were discharged from the hospital. Other hospital services and supplies, such as: • Operating, recovery, maternity, birthing centers and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	
• Administration of blood and blood products • Blood or blood products, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items (except medications) • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Private nursing care	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Take home medications*	*All Charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood products, and other biologicals • Blood and blood products, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Telemedicine services provided by the use of real time interactive audio and video communication or time delayed transmission of medical information between the patient at the originating site and a provider at another location for diagnosis, consultation, or treatment. Services must be provided by a Washington state licensed physician. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental, physical impairment. We do not cover the dental procedures.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Take home medications* • *Audio-only, telephone, fax and e-mail communications*	*All Charges*

Benefit Description	You Pay After the calendar year deductible...
Extended care benefits/Skilled nursing care facility benefits	
When appropriate, as determined by a doctor and approved by us, we cover full-time skilled nursing care with no dollar or day limit. Intensive physical and occupational therapies in a skilled nursing facility apply toward the maximum 60 combined visits per condition. Extended care benefits require preauthorization by our medical director.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care*	*All Charges*
Hospice care	
Supportive and palliative care for a terminally ill member is covered when services are provided under the direction of a doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less. Services include: • Medical care • Family counseling Inpatient hospice benefits are available only when services are preauthorized and determined necessary to: • Control pain and manage the patient's symptoms; or • Provide an interval of relief (respite) to the family not to exceed seven (7) consecutive days; each respite care admission must be preauthorized and separated by at least 21 days.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Independent nursing, homemaker services*	*All Charges*
Ambulance	
Coverage for ambulance services includes: • Ground transportation • Air transportation Air ambulance transportation is subject to review and approval by us. In cases where the patient's condition does not warrant air transportation, coverage will be based on the benefit for ground transportation.	20% of Plan allowance
Note: If you are hospitalized in a non-Plan facility and Plan doctors believe care can be provided in a Plan hospital, you may ask to be transferred to a Plan provider when medically feasible with any ambulance charges covered in full.	
Not covered: • *The use of any type of ambulance transportation for personal convenience.*	*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 deductible is $1,500 for Self Only enrollment, $1,500 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,000 (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room.

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

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

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

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

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient in a hospital, including doctors' services	20% of Plan allowance
Not covered: • *Elective care or non-emergency care*	*All Charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient in a hospital, including doctors' services	20% of Plan allowance
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All Charges*
Ambulance	
Professional ambulance service when medically appropriate. • Ground transportation • Air transportation In cases where the patient's condition does not warrant air transportation, coverage will be based on the benefit or ground transportation. Note: If you are hospitalized in a non-Plan facility and Plan doctors believe care can be provided in a Plan hospital, you may ask to be transferred to a Plan provider when medically feasible with any ambulance charges covered in full. See Section 5(c), for non-emergency service.	20% of Plan allowance
Not covered: • *The use of any type of ambulance transportation for personal convenience.*	*All Charges*

Section 5(e). Mental health and substance misuse 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.
- The calendar year deductible is $1,500 for Self Only enrollment, $1,500 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,000 (each applies separately for services received from Plan providers and non-Plan providers). The deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.
- **YOU MUST GET PREAUTHORIZATION FOR INPATIENT SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
- All inpatient stays must be preauthorized by the Plan. You or your mental health or substance misuse disorder treatment provider must obtain preauthorization by calling 800-223-6114 before services are provided. If preauthorization is not obtained, a retro-review may be done to determine if the services are covered and if they were medically necessary. Services that are not preauthorized will be reduced by 20%. Please see Section 3, "What happens when you don't follow the preauthorization rules."

We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required

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

- 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 After the calendar year deductible...
Professional services	
We cover professional services by licensed professional mental health and substance misuse disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Outpatient diagnostic tests provided and billed by a licensed mental health and substance misuse disorder treatment practitioner • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy)	In-network: 20% of Plan allowance Nothing for group sessions Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount Nothing for group sessions

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Professional services (cont.)	
• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug misuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Applied Behavioral Analysis (ABA) therapy - limited to outpatient treatment of an autism spectrum disorder as diagnosed and prescribed by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnosis and treatment of autism. Documented diagnostic assessments, individualized treatment plans and progress evaluations are required.	In-network: 20% of Plan allowance Nothing for group sessions Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount Nothing for group sessions
Diagnostics	
• 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	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Inpatient hospital or other covered facility	
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 • Professional services of physicians	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Physical, Occupational and Speech Therapies	
Services must be provided by qualified physical, occupational, or speech therapists.	In-Network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible...
Not Covered	
• *Services that, upon review, are determined to be inappropriate to treat your condition or are Plan exclusions.* • *Long-term rehabilitative therapy* • *Exercise programs*	*All Charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart on page 120.
- 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.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- The deductible is $1,500 for Self Only enrollment, $1,500 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,000 (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

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

- **Who can write your prescription.** A physician, podiatrist, advanced registered nurse practitioner (ARNP), physician assistant (PA), midwife, or dentist who is licensed and provided with prescription authority from the jurisdiction of their practice must prescribe your medication.

Note: Some drugs require prior authorization and may be limited to a specific quantity or day supply (see Section 3. **Other services**, regarding prior approval.

- **Where you can obtain them.** You must fill the prescription at a Plan retail pharmacy or through a Plan mail order program, except for emergencies. If you have any questions regarding your pharmacy benefit, please call Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711
- **Mail Order Program.** Covered prescription drugs are available through the mail order program. Prescriptions ordered through this program are subject to the same copayments, guidelines, and limitations set forth above. Mail order issues up to a 90-day supply per fill. To begin using mail order, or to transfer an existing prescription from a retail pharmacy, ask your prescriber to send the prescription directly to the mail order pharmacy.

Kaiser Permanente
Mail Order Pharmacy
P.O. Box 34383
Seattle, WA 98124-1383

Phone: 800-245-7979
Fax: 206-901-4443

- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply per fill, except for certain drugs, which may be dispensed on a 90-day supply basis with two (2) copayments. For prescribed hormonal contraceptives, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program. If a drug is a Tier 4 or Tier 5 drug, you will pay the applicable coinsurance. Refills for any prescription drug cannot be obtained until at least 75% of the drug has been used. Drugs designated as specialty may be covered for up to a 30-day supply per fill. If you have a new prescription for a chronic condition, you may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity.
- **A generic equivalent will be dispensed if it is available.** If your physician believes that a name brand product is medically necessary, or if there is no generic equivalent available, your physician may prescribe a name brand drug. If you elect to purchase a name brand drug instead of the generic equivalent you are responsible for paying the difference in cost in addition to the prescription drug cost share.

Plan members called to active military duty (or members in the time of national emergency) who need to obtain prescribed medications should Call Member Services toll-free at 888-901-4636.

We have an open Drug Formulary. Drug Formulary (approved drug list) is defined as a list of preferred pharmaceutical products the Pharmacy MOST drugs into one of five "tier" categories:

- Tier 1 generally includes generic drugs, but may include some brand formulary or preferred brands. Usually represents the lowest copays.
- Tier 2 generally includes brand formulary and preferred brand drugs, but may include some generics and brands not included in Tier 1. Usually represents brand or middle-range copays.
- Tier 3 may include all other covered drugs not on tiers 1 and 2 (i.e., non-formulary or non-preferred).
- Tier 4 includes preferred specialty drugs.
- Tier 5 includes non-preferred specialty drugs.

Because of their lower cost to you, we recommend that you ask your provider to prescribe preferred drugs as the first choice of therapy. To order a Drug Formulary, call us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. You may also access the Drug Formulary on our website at www.kp.org/wa/fehb-options.

Preferred drugs are branded, single source or multi-source agents, or generic drugs that are determined to be preferred by us.

Non-preferred drugs are branded, single source or multi-source agents, or generic drugs that are determined to be non-preferred by us.

Note: The Drug Formulary is continually reviewed and revised. We reserve the right to update this list at any time. **For the most up-to-date information about our Drug Formulary, visit our website at www.kp.org/wa/fehb-options.**

- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. They must contain the same active ingredient and must be equivalent in strength and dosage to the original brand name product. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic drug costs you – and us – less than a name brand drug.
- **When you do have to file a claim.** When you use a Plan pharmacy, you will not be responsible for submitting a claim form to the Plan. In the event of an accidental injury or medical emergency, you may utilize the services of a non-Plan pharmacy. For reimbursement of pharmacy claims, please submit an itemized claim form with the following information:

  - Member's name and ID#
  - Drug name, quantity, prescription number
  - Cost of drug and amount you paid
  - NDC number
  - Drug strength

- Pharmacy name
- Pharmacy address
- Pharmacy NABP number

Submit your request for reimbursement to:

Member Claims
P.O. Box 34585
Seattle, WA 98124-1585

- **For additional information** on your pharmacy benefits, call Member Services at 888-901-4636.
- **Specialty medications.** Certain medications must be ordered only through our specialty drug pharmacy program. Your physician must obtain preauthorization for these medications. For a list of specialty drugs, please go to Drug Lists on our website at www.kp.org/wa/fehb-options or call Member Services toll-free at 888-901-4636 prior to receiving services.

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	
We cover the following medications and supplies prescribed by a physician and obtained from a Plan retail pharmacy or through the mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction limited to eight (8) pills per prescription per month • Preauthorized compounded drugs • Hormone therapy	**Tier 1** $20 per prescription/refill $40 per 90-day supply **Tier 2 – Preferred** $40 per prescription/refill $80 per 90-day supply **Tier 3 – Non-Preferred** $60 per prescription/refill $120 per 90-day supply **Tier 4 – Preferred Specialty** 25% up to a maximum out of pocket of $200 per 30-day supply **Tier 5 – Non-Preferred Specialty** 35% up to a maximum out of pocket of $300 per 30-day supply
Women's contraceptive drugs and devices (s*ee Preventive care, adult*) Note: Over-the-counter contraceptive drugs and devices, including emergency contraceptives, approved by the FDA require a written prescription by an approved provider. Contraceptive drugs purchased at a non-Plan pharmacy are not covered, except emergencies.	Nothing (No deductible)

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
Mail Order Drug Program • Prescription medications mailed to your home by the Kaiser Permanente Washington mail order pharmacy (mail order issues up to a 90-day supply per fill.)	**Tier 1** $20 per prescription/refill $40 per 90-day supply **Tier 2 – Preferred** $40 per prescription/refill $80 per 90-day supply **Tier 3 – Non-Preferred** $60 per prescription/refill $120 per 90-day supply Mail order not available for specialty drugs
Limited benefits • Drugs to aid in tobacco cessation when prescribed and dispensed as part of the Plan's tobacco cessation program • Over-the-counter tobacco cessation drugs when obtained through the Kaiser Permanente Washington mail order pharmacy and Plan retail pharmacy	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except treatment of phenylketonuria (PKU) as described elsewhere in this brochure* • *Non-prescription medicines, except certain over-the-counter substances approved by the Plan* • *Medical supplies such as dressings and antiseptics* • *Fertility drugs* • *Drugs to enhance athletic performance* • *Drugs prescribed to treat any non-covered service* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Compounded drugs for hormone replacement therapy* • *Drugs that are not medically necessary according to accepted medical, dental or psychiatric practice as determined by the Plan* • *Lost or stolen medications* • *Non-self administered medications (e.g., intramuscular, intravenous, intrathecal)* • *Weight loss medications* *Note: Over-the-counter and prescription drugs authorized by the Quit For Life® program and approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit (see Educational classes and programs).*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Preventive Care Medications	
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 • Liquid iron supplements for children age 0-1 year • Vitamin D to reduce the risk of falls • Medications to reduce the risk of breast cancer • Statins for adults at risk of cardiovascular disease Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network 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 (No deductible)

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 the first/primary payor of any benefit payments and your FEDVIP plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with Medicare and other coverage*.
- The deductible is $1,500 for Self Only enrollment, $1,500 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,000 (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c), for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. Sound natural teeth are those that do not have any restoration. (See Section 10, *Definitions of terms we use in this brochure*.) The need for these services must result from an accidental injury (not biting or chewing). All services must be performed and completed within 12 months of the date of injury. Note: This benefit is not part of the *Dental preventive care* benefit.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Dental benefits	Definition
See *Dental preventive care*. We have no other dental benefits.	

Section 5(h). Wellness and other special features

Feature	Description
Flexible benefits option	In certain cases, Kaiser Permanente Washington Options Federal, at its sole discretion, may choose to authorize coverage for benefits or services that are not otherwise included as covered under this Plan. Such authorization is done on a case-by-case basis if a particular benefit or service is judged to be medically necessary, beneficial and cost effective. However, our decision to authorize services in one instance does not commit us to cover the same or similar services for you in other instances, or to cover the same or similar services in any other instance for any other enrollee. Our decision to authorize services does not constitute a waiver of our right to enforce the provisions, limitations and exclusions of this Plan. 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 claim process (see Section 8).
Consulting Nursing Service	For urgent care information and after hours care 24 hours a day, 7 days a week, call toll-free 800-297-6877.
Services for deaf, hard of hearing or speech impaired	We provide a TTY/text telephone number at: 711. Sign language services are also available.
Travel benefit/services overseas	If you are on Temporary Duty Assignment or reside temporarily outside of Washington state you are covered for all of the benefits described in this brochure. You pay the applicable cost-share per visit for services. For non-urgent and non-emergent services you should receive care from a Plan provider; in Idaho, Oregon, Montana and Alaska, a Plan provider is a First Choice Health Network provider and in all other states a Plan provider is a First Health Network provider. Medications obtained at a participating pharmacy in connection with non-urgent, non-emergent services will also be covered. See also Section 1. "How we pay providers". If you need assistance while anywhere in the world call Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington State's relay line by dialing either 800-833-6388 or 711.

	Filing Overseas Claims for Urgent or Emergent Care Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement**. To file a claim for urgent or emergent care received outside the United States, send a completed Overseas Claim Form and itemized bills to: Member Claims P.O. Box 34585 Seattle, WA 98124-1585 We will do the translation and currency conversion for you. You may obtain the Overseas Claim Form by calling Member Services toll-free at 888-901-4636 or from our website at www.kp.org/wa/fehb-options, Members/Forms and Information.

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

Special features	Description
Health education resources	Through our website at www.kp.org/wa/fehb-options you will find information on: • General health topics • Links to health care news • Cancer and other specific diseases • Drugs/medication interactions • Kids' health • Patient safety information • Helpful website links
Account management tools	For each HSA and HRA account holder, complete payment history and balance information can be found online at www.MyHealthEquity.com. This information is also available by calling the HealthEquity® customer service line toll-free at 866-346-5800. You may view monthly statements, year-end statements and tax statements online at healthequity.com. If you have an HSA, you may also change your investment options online at www.MyHealthEquity.com.
Consumer choice information	As a member of this HDHP, you may choose any provider. However, you will pay less out-of-pocket when using a network provider. Directories are available online at www.kp.org/wa/fehb-options by clicking on Members/Find a Provider. See pages 14 and 19 for further information. Pricing information for prescription drugs and a link to our online pharmacy are available at www.kp.org/wa/fehb-options by clicking on Pharmacy. Educational materials regarding HSAs and HRAs are available at www.myhealthequity.com.
Care support	Patient safety information is available online at www.kp.org/wa/febh-options.

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 a FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximum. These programs and materials are the responsibility of the Plan and all appeals must follow their guidelines. For additional information contact the Plan at 888-901-4636 or visit our website at www.kp.org/wa/fehb-options.

Additional Benefits

Vision hardware discount - Shop at convenient Kaiser Permanente Eye Care locations.

- Get a 20% vision hardware discount on eyeglasses or prescription sunglasses.
- Get a 20% discount on contact lenses once a year.
- Fitting and evaluation fees are not discounted. Call Member Services toll-free at 888-901-4636, or go online to www.kp.org/wa/eyecare for more information.

Mobile App

Our convenient smartphone app - You can use your smartphone to access many of the features you enjoy online at our password protected member website. You can find maps of Kaiser Permanente care locations as wait times for lab and pharmacy at nearby Kaiser Permanente medical offices.

Additional Services

Kaiser Permanente Audiology/Hear Center - Get a full range of the latest hearing aid technology from leading manufacturers, as well as other custom devices and accessories at Kaiser Permanente care locations in Everett, Bellevue, Seattle, Tacoma, and Olympia.

24-hour Consulting Nurse Service - When you want care advice or need to know if you should get immediate medical attention, Kaiser Permanente Washington's Consulting Nurse Service can help 24 hours a day. For assistance, call 800-297-6877.

Wellness Programs

Health Profile - Uncover your risks and make positive changes with support from Kaiser Permanente Washington. Learn more once you're registered at www.kp.org/wa/fehb-options.

Wellness visits - Schedule immunizations and screening tests based on age and gender.

Fitness club and discounts - Find out more at www.globalfit.com/kpwa.

Tobacco cessation - Giving up smoking isn't easy, but Kaiser Permanente Washington offers a highly successful program with a 49% quit rate. For more information, visit www.quitnow.net/kpwa.

Online Services

Kaiser Permanente member website - Online services at www.kp.org/wa/fehb-options are available for all members. Select doctors and read their profiles, see medical care locations and programs, and browse thousands of health care topics. Plus, you can refill pharmacy prescriptions, view or download your FEHB Brochure, and take the Health Profile to assess your health.

Getting care at Kaiser Permanente medical offices - When you log on to www.kp.org/wa/fehb-options you can exchange secure messages with your health care team, check your online medical record, get your lab and test results, and request an appointment.

Individual and family plans - Consider a range of individual and family plans for those who do not qualify for coverage under the FEHB program. Learn more at www.kp.org/shop.

For more information about these and other benefits available to Kaiser Permanente Washington Options Plan members, please call Member Services at 888-901-4636 toll-free or go online to our website at www.kp.org/wa/fehb-options.

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary as determined by the Plan.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices as determined by the Plan (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies 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.
- Research costs for clinical trials (see Section 9, and Section 10).
- Services provided by a person who is related to you by blood or marriage.
- Charges for non-covered benefits and services and resulting complications, including services not specifically described in this Plan.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs, equipment, or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs, equipment, or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible (if applicable).

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing 800-833-6388 or 711, or at our website at www.kp.org/wa/fehb-options.

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

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- 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 Washington Options Federal
Member Claims
PO Box 34585
Seattle, WA 98124

Prescription drugs

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

- Member’s name and ID number
- Drug name, quantity, prescription number
- Cost of drug and amount you paid
- NDC number
- Drug strength
- Pharmacy name
- Pharmacy address
- Pharmacy NABP number

Submit your claims to:

Claim Reimbursement
P.O. Box 34585
Seattle, WA 98124-1585

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 procedures

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

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

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

Authorized Representative

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

Notice Requirements

If you live in a county where at least 10 percent 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 telephone 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 health care 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 visit www.kp.org/wa/fehb-options.

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, equipment 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, equipment 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 Member Services Department by writing to Kaiser Permanente Washington Options Federal, P.O. Box 34593, Seattle, WA 98124-1593 or calling 888-901-4636.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

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 health care 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 his/her 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.

Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Kaiser Permanente Washington Options Federal Appeals Department PO Box 34593 Seattle, WA 98124-1593 or fax your request to: 206-901-7340; 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) e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim; or

b) Write to you and maintain our denial; or

c) Ask you or your provider for more information.

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

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

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

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

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E Street NW, Washington, DC 20415-3620.

Send OPM the following information:

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

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

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

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

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

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to 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 preauthorization 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 877-828-4514. 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 Health Insurance 2 at (202) 606-3818 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 dependent 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 health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other 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 our website at www.kp.org/wa/fehb-options.

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

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. When we are the secondary payor, we will coordinate benefits with the primary payor allowing up to our Plan's benefit visit maximum.

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

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

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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.

If you are a participant in a clinical trial, this health Plan will provide related care as follows, if it is not provided by the clinical trial:

- **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. These costs are covered by this Plan.
- **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. This Plan covers some of these costs, providing the Plan determines the services are medically necessary. For more specific information, we encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.
- **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.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 800-MEDICARE (800-633-4227), (TTY 800-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 138.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 800-772-1213 (TTY 800-325-0778) to set up an appointment to apply. If you do not apply for one or more parts of Medicare, you can still be covered under the FEHB Program.

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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

- **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 toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711, or see our website at www.kp.org/wa/fehb-options.

We waive some cost-sharing if Original Medicare Plan is your primary payor and you use a provider who accepts Medicare assignment.

When you have Medicare Parts A and B, Medicare is primary payor and you receive care from a provider that accepts Medicare, we waive some out-of-pocket costs as follows:

Benefit Description	**Standard Option without Medicare** You pay	**Standard Option with Medicare** You pay
Deductible	$350	$0
Out of Pocket Maximum	$5,000 per person up to $10,000 per family	$5,000 per person up to $10,000 per family
Primary Care Physician	$25	$0
Specialist	$35	$0
Inpatient Hospital	20%	$0
Outpatient Hospital	20%	$0
RX	Tier 1 - $20 Tier 2 - $40 Tier 3 - $60 Tier 4 - Preferred Specialty 25% to $200 Tier 5 - Non-preferred Specialty 35% to $300	Tier 1 - $20 Tier 2 - $40 Tier 3 - $60 Tier 4 - Preferred Specialty 25% to $200 Tier 5 - Non-preferred Specialty 35% to $300
Rx - Mail order (90-day supply)	2x retail copay	2x retail copay

If you have Medicare Part A only, and Original Medicare is your primary payor, we will waive deductible, coinsurance, and copayments for Part A services **only** (such as inpatient hospital care, home health, hospice, or skilled nursing care).

If you have Medicare Part B only, and Original Medicare is your primary payor, we will waive deductible, coinsurance, and copayments for Part B services **only** (such as outpatient medical or surgical care).

We will not waive the following:

- Cost-sharing for members who do not have Medicare Parts A or B, or, for whom Medicare is secondary payor
- Prescription drug cost-sharing
- Cost-sharing for HDHP members

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY 800-486-2048) or at www.medicare.gov.

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

This Plan and 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 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 Medicare Part D and we are the secondary payor, 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.

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Clinical Trials Cost Categories

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

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 26.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 26.

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.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Care you receive in an institution, such as room and board or other supportive care, or in your home that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist you in activities of daily living. Activities of daily living include but are not limited to: help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets, and supervision of medications that you would normally self-administer. Custodial care that lasts 90 days or more is sometimes known as long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 26.

Experimental or investigational services

The Plan makes its determination of experimental or investigational treatment, including medical and surgical services, drugs, devices and biological products upon review of evidence provided by evaluations of national medical associations, consensus panels, and/or other technological evaluations, including the scientific quality of such supporting evidence and rationale. The information it reviews comes from the U.S. Food and Drug Administration and from scientific evidence in published medical literature, as well as in published peer-reviewed medical literature.

Health care professional

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

Medical necessity

Medical services or hospital services which are determined by the Plan Medical Director or designee to be:

- Rendered for the treatment or diagnosis of an injury or illness; and
- Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and
- Not furnished primarily for the convenience of the Member, the attending physician, or other provider of service.

Whether there is "sufficient scientific evidence" shall be determined by the Plan based on the following: peer-reviewed medical literature; publications, reports, evaluations, and regulations issued by state and federal government agencies; Medicare local carriers, and intermediaries; and such other authoritative medical sources as deemed necessary by the Plan.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. You will be required to pay any difference between the non-Plan providers charge for services and the Allowed Amount.

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 or prior approval and (2) where failure to obtain precertification or prior approval 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 out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Sound natural tooth

A sound natural tooth is a tooth that is whole or properly restored (restoration with amalgams/resin-based composites only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. A tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics is not considered a sound natural tooth.

Subrogation

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

Us/We

Us and We refer to Kaiser Foundation Health Plan of Washington Options, Inc., Kaiser Permanente Washington Options Federal, Options Federal or Kaiser Permanente.

You

You refers to the enrollee and each covered family member.

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

If you believe your claim qualifies as an urgent care claim, please contact our Member Services Department toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. 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.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	The fixed amount of covered expenses you must incur during the calendar year for certain covered services and supplies before we start paying benefits for those services. See page 26 for more information.
Catastrophic limit	The maximum amount you will have to pay in a calendar year towards copayments, coinsurance, and deductible for certain covered services. See page 27 for more information.
Health Reimbursement Arrangement (HRA)	An HRA allows you to pay for certain medical expenses using funds contributed by the Plan. Money left at the end of the year may be rolled over to the following year as long as you remain with the Plan. See page 84 for more information.
Health Savings Account (HSA)	An HSA allows you to pay for certain medical expenses using funds contributed by the Plan and/or yourself as long as you are covered only by a High Deductible Health Plan (HDHP). Money left at the end of the year may be rolled over to the following year and remains yours even if you leave the Plan. See page 83 for more information.
Premium contribution to HSA/HRA	The amount of money from your premium payment that the Plan contributes to your HSA or HRA account. See page 80 for more information.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about four Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

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

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

Fourth, The **Federal Employees Group Life Insurance Program (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,600 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** - Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA)** - Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

- **Dependent Care FSA (DCFSA)** - Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 877-FSAFEDS 877-372-3337 (TTY: 866-353-8058), Monday through Friday, 9 a.m. until 9 p.m. Eastern Time.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.

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

Dental Insurance

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia but it may be limited. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

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

Additional Information

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

How do I enroll?

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

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

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

The Federal Employees' Group Life Insurance Program - *FEGLI*

Peace of Mind for You and Your Family

The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

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

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Notes

Summary of benefits for the Standard Option of Kaiser Permanente Washington Options Federal - 2018

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

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit: $25 copayment for primary care services or $35 copayment for specialty care services	32
Services provided by a hospital:		
• Inpatient & outpatient	20% of Plan allowance*	56
Emergency benefits:		
• In-area/Out-of-area	Emergency Room: $150 copayment*	60
• In-area/Out-of-area	Urgent Care: $25 copayment for primary care services or $35 copayment for specialty care services	60
Mental health and substance misuse disorder treatment:	Regular cost sharing*	61
Prescription drugs:		
• Retail pharmacy	Tier 1: $20; Tier 2: $40; Tier 3: $60; Tier 4: 25% up to a maximum out of pocket of $200 per 30-day supply; Tier 5: 35% up to a maximum out of pocket of $300 per 30-day supply	66
• 90-day supply	Tier 1: $40; Tier 2: $80; Tier 3: $120	66
Dental care: Preventive dental care	All charges in excess of the fee schedule allowance.	68
Vision care: Annual eye exam	Nothing	33; 35
Wellness and other special features:	See Section 5(h)	70
Point of Service benefits:	See Section 5(i)	72
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/person or $10,000/family per year. Some costs do not count toward this protection	27

Summary of benefits for the HDHP of Kaiser Permanente Washington Options Federal - 2018

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

In 2018, for each month you are eligible for a Health Savings Account (HSA), we will deposit $62.50 per month for Self Only enrollment or $125 per month for Self Plus One or Self and Family enrollment into your HSA. For the High Deductible Health Plan (HDHP), you may use your HSA or pay out of pocket to satisfy your calendar year deductible of $1,500 for Self Only enrollment and $1,500 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,000 (each applies separately for services received from Plan providers and non-Plan providers). Once you satisfy your calendar year deductible, Traditional medical coverage begins.

If you are not eligible for an HSA, we will establish a Health Reimbursement Arrangement (HRA) account for you with an annual credit of $750 for Self Only enrollment and $1,500 for Self Plus One or Self and Family enrollment.

Below, an asterisk (*) means the item is subject to the $1,500 per person Self Only ($1,500 per person Self Plus One or Self and Family, not to exceed a total family deductible of $3,000) calendar year deductible.

HDHP Benefits	You Pay	Page
In-network medical preventive care:	Nothing	85
Preventive dental care:	All charges in excess of the dental fee schedule allowance	87
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	In-network: 20% of Plan allowance* Out-of-network: 40% of Plan allowance*	90
Services provided by a hospital: Inpatient & outpatient	In-network: 20% of Plan allowance* Out-of-network: 40% of Plan allowance*	56
Emergency benefits: In-area & out-of-area	20% of Plan allowance*	114
Mental health and substance misuse disorder treatment:	In-network: 20% of Plan allowance* Out-of-network: 40% of Plan allowance*	115
Prescription drugs:		
• Retail pharmacy	Tier 1: $20*; Tier 2: $40*; Tier 3: $60*; Tier 4: 25% up to a maximum out of pocket of $200 per 30-day supply*; Tier 5: 35% up to a maximum out of pocket of $300 per 30-day supply*	120
• 90-day supply	Tier 1: $40*; Tier 2: $80*; Tier 3: $120*	120
Dental care - Accidental injury only:	In-network: 20% of Plan allowance* Out-of-network: 40% of Plan allowance*	123
Vision care: Annual eye exam	Nothing (included in Preventive Care)	85; 86
Wellness and other special features:	See Section 5(h)	124
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/person or $10,000/family per year (each applies separately for services received from Plan providers and non-Plan providers). Some costs do not count toward this protection.	27

2018 Rate Information

For 2018 FEHB plan premium information, please see:

https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/ or contact your tribal employer's Human Resources department.