KPS Health Plans

www.kpsfederal.com

Customer Service 1-800-552-7114

2014

A Prepaid Comprehensive Medical Plan (high and 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 8 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2014: Page 16
- Summary of benefits: Page 151

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 15 for requirements.

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

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-051

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

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

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Introduction

This brochure describes the benefits of KPS Health Plans under our contract (CS 1767) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Service may be reached at 360-478-6796 or toll-free at 1-800-552-7114 or through our website: www.kpshealthplans.com. The address for KPS Health Plans' administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2014, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2014, and changes are summarized on page 16. 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 KPS Health Plans.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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 at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE
1-877-499-7295

OR go to www.opm.gov/oig

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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines 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.

3. Get the results of any test or procedure.

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

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

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

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

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

Patient Safety Links

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

- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use KPS Plan providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (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**

  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.

- **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 who participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

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

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

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

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

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

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

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

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.

Children	Coverage
Natural, 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.

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 and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- **Children's Equity Act (cont.)**

  - If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
  - If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

- **When benefits and premiums start**

  The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or Plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2014 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 2013 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

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

If you leave Federal service, tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, 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, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

- **Finding replacement 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 apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

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

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711or visit our website at www.kpshealthplans.com.

- **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.

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

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

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

Section 1. How this plan works

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

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

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

Questions regarding what protections apply may be directed to us at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 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 High and Standard Options

Both High and Standard options provide comprehensive medical, surgical and hospitalization benefits in addition to coverage for alternative care providers, dental benefits, mental health care, and an open 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 High and Standard Option Section 5(i), page 80, for POS benefit details.

How we pay providers

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

We emphasize comprehensive medical and surgical care received from Plan providers. A Plan provider is any facility or licensed practitioner who contracts with KPS or the First Choice Health Network (FCHN). A Plan pharmacy is a pharmacy contracted with our pharmacy benefit management company, MedImpact, 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 receive services in Clallam, Jefferson, Kitsap, and Mason counties you must use providers contracted directly with KPS. Outside of those counties, you must use providers contracted with FCHN.

When traveling or temporarily residing outside the state of Washington (e.g., while on Temporary Duty Assignment), you are covered for urgent/emergent care only. 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 at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 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. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $4,000 for Self Only enrollment, or $8,000 for Self and Family coverage (each applies separately for services received from Plan providers and non-Plan providers).

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

If you are enrolled in a Wells Fargo Health Savings Account (HSA),

- A Wells Fargo new enrollee welcome letter with your account information will be mailed to you shortly after enrolling.
- Convenient access to HSA funds is made available through a Wells Fargo Health Savings Account Visa® debit card.
- At the Wells Fargo Web site (www.wellsfargo.com/hsa) you can easily view account balances and information, change investment options, download forms and link to a list of covered expenses.

- Through the Wells Fargo toll-free HSA customer service line at 1-866-884-7374 you can access automated information 24 hours a day, or speak with a helpful customer service representative from 5:00 am to 5:00 pm, Monday through Friday, Pacific Time.

If you are enrolled in a Health Reimbursement Arrangement (HRA),

- HealthSmart Benefit Solutions will mail you a Benefits Debit MasterCard® that you can use like a debit card to pay for eligible medical expenses.
- You can access information about your account by going to www.healthsmart.com and clicking on the "Members" box at the bottom of the page.
- HealthSmart Benefit Solutions customer service representatives can be reached at 1-800-503-9098, Monday through Friday, 7:00 am to 7:00 pm, Eastern Time.

Other important tools and information are available by visiting the KPS Web site at www.kpsfederal.com.

For more details please refer to the HDHP **Section 5(i) Health education resources and account management tools** on page 130**.**

Your rights

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

- Years in existence
- Profit status

If you want more information about us, call 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711, or write to P.O. Box 339, Bremerton, Washington 98337. You may also contact us by fax at 360-415-6514 or visit our Web site at www.kpsfederal.com.

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 page 13, 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 High and Standard Option, page 80, and page 84 for the HDHP *Out-of-network services.*

Note: When you are outside our service area, you are only covered for urgent/emergent care. Urgent/emergent care services are covered at the Plan provider benefit level as described on page 60 and 119.

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 2014

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.

Program wide changes

Changes to this Plan

Changes to High Option only

- Your share of the non-Postal premium will increase for both Self Only and Self and Family enrollment. See page 158.
- We now include your copayments, pharmacy copayments, and coinsurance (some exceptions apply) in the annual catastrophic protection out-of-pocket maximum. See page 26.

Changes to Standard Option only

- Your share of the non-Postal premium will increase for both Self Only and Self and Family enrollment. See page 158.
- We now include your deductible, copayments, pharmacy copayments and coinsurance (some exceptions apply) in the annual catastrophic protection out-of-pocket maximun. See Page 26.
- We now cover the first four (4) combined office visits of the year at 100% after a $15 copayment per visit per enrollee with the annual deductible and coinsurance applied to subsequent visits. See pages 31-46.
- We no longer waive the annual deductible for the first six (6) months of treatments for accidental injuries. See page 25.

Changes to our High Deductible Health Plan (HDHP)

- Your share of the non-Postal premium will increase for both Self Only and Self and Family enrollment. See page 158.
- We have lowered the annual catastrophic protection out-of-pocket maximum for Self Only to $4,000 and for Self and Family to $8,000 (each are still applied separately for Plan and non-Plan providers). See pages 26 and 86.

Changes to High and Standard Option

- We now apply out-of-pocket maximums to members without Medicare. If you are enrolled with a member who has out-of-pocket expenses waived based on their Medicare coverage, but you do not have Medicare, you will now be responsible for benefit cost-shares that apply to non-Medicare enrollees. See page 141.

Changes to Standard Option and High Deductible Health Plan (HDHP)

- We have changed the Standard Option and HDHP Plans from grandfathered status to non-grandfathered status based on guidance from the U.S. Office of Personnel Management.

Changes to all KPS plans

- We have increased the number of covered chiropractic, acupuncture, and massage therapy treatments to 20 each. See pages 43 and 105.
- We have changed the bariatric surgery criteria. See pages 48 and 109.
- We have increased the number of consecutive days for inpatient hospice care from five (5) to seven (7) and apply the restriction to inpatient respite hospice care only. See pages 58 and 118.
- We now cover Tier 3 prescription drugs with a $50 copayment for a 30-day supply and allow a 90-day supply with a $100 copayment. See pages 68 and 126.
- We have updated the dental codes and fees for topical application of fluoride based on changes made by the American Dental Association. See pages 71 and 95.

- We now cover aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-Cell lymphomas and aggressive Dendritic Cell neoplasms) under our Organ/tissue transplants benefit. See pages 54 and 114.
- We cover Habilitative therapy services under the physical and occupational therapies benefits. See pages 37 and 101.

Benefit Clarifications/Correction

- We have clarified that the initial exam of a newborn child covered under a family enrollment is paid at 100% under **Preventive care, children**. See pages 33 and 94.
- We have clarified that Waldenstrom's macroglobulinemia, Scleroderma and Scleroderma-SSc (severe, progressive) are covered under the benefit for **Organ/tissue transplants**. See pages 52, 54, 112 and 115.
- We have clarified that the maximum air ambulance transportation benefit is $5,000 per trip. See pages 58, 62, 118 and 120.
- We have made clarifications to the **Prescription drug benefits** information. See pages 66-69 and 124-127.
- We have clarified the dental benefit coverage restriction regarding missing teeth. See page 77.
- We have clarified that pharmacy copayments are included in the HDHP annual catastrophic protection out-of-pocket maximum. See page 26.
- We have clarified that the HDHP **Diagnostic and treatment services** benefit applies to services received in your home. See page 97.

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 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711, or write to us at P.O. Box 339, Bremerton, Washington 98337. You also may request replacement cards through our Web site at www.kpsfederal.com by logging into **MyKPS** and choosing Resources/Online Customer Service.

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.

Note: When you are outside our service area, you are only covered for urgent/emergent care. Urgent/emergent care services are covered at the Plan provider benefit level as described on page 60.

- **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 Web site at www.kpsfederal.com by clicking on Members/Find a Provider or upon request by calling Customer Service at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 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 Web site at www.kpsfederal.com 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 timeframes 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 80, for High and Standard Option and page 84 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, and massage therapy are each limited to 20 treatments per calendar year.

  The non-Plan provider reduction in benefits applies (see High and Standard Option Section 5(i), *Point of Service benefits*, page 80, and HDHP Section 5, *High Deductible Health Plan Benefits Overview, Out-of-network services*, page 84).

- **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 Customer Service department immediately at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 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 Plan provider must obtain benefit authorization for the extension.

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

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

- **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. You or your physician 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.

- Blepharoplasty
- Bone growth stimulators
- Breast surgeries
- CPM machines
- Depo-Lupron
- Electric scooters
- Enteral therapy
- Genetic testing
- Growth hormone treatment (pre-authorized by MedImpact)
- Home health & hospice
- Home IV infusion
- Hyperbaric oxygen pressurization
- Inpatient services

- Insulin pump
- LAUP
- Medications provided by a Specialty pharmacy
- Medications used for treatment of cancers
- Inpatient mental health & substance abuse treatments
- Organ transplants
- Penile prosthesis
- PET scans
- Pneumatic compression device
- Pulse dye laser
- Removal of scars
- Respiratory syncytial virus agent (RSV)
- Sclerotherapy
- Skilled nursing facility care
- Sleep disorders surgery
- SPECT scans
- Synchromed pump
- UPPP
- Urinary incontinence treatment w/biofeedback
- Ventilators

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 at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711 before admission, services, or equipment requiring prior authorization are rendered.

Customer Service will confirm that the service, treatment, or equipment requires preauthorization. If it does, you will be transferred to the Medical Management department where all the information needed to determine authorization will be taken, including the following:

- 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 planned days of confinement.

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

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

- **Urgent care claims**

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

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

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

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 360-478-6796 or toll-free at 1-800-552-7114. 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 at 360-478-6796 or toll-free at 1-800-552-7114. 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 you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules

If 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. KPS will not pay for services or treatments that are not covered or that are not medically necessary.

If the hospitalization and treatment is not preauthorized, our allowance for the admitting physician's fees and benefits for the hospital stay will be reduced by 20%. The same reduction applies to inpatient mental health or substance abuse 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 was due. We will base our decision on the information we already have. We will write to you with our decision.
  3. Write to you and maintain our denial.
- **To reconsider an urgent care claim** — In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will 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 Plan doctor's office. These facilities are more convenient than a hospital because surgery can be scheduled easily and quickly, and the patient can return home sooner. The cost of surgery is reduced because hospital room and board charges are eliminated.

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

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

The 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 Customer Service at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 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 High Option, you pay a copayment of $30 per office visit.

Under Standard Option, you pay a copayment of $15 (no deductible) per visit for the first four (4) professional office visits (the first four visits may be any combination of primary care, alternative care, rehabilitation, mental health/substance abuse visits) then applicable deductible and 20% coinsurance.

Example:

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

Under the High Deductible Health Plan (HDHP), once you have met the annual deductible, you pay a $10 copayment for Tier 1 drugs and a $35 copayment for Tier 2 drugs.

Deductible

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

- **There is no annual deductible for High Option medical benefits.** You will, however, pay an annual deductible of $25 per member ($50 maximum per family) for basic and major dental care and all charges in excess of the scheduled fee allowance.
- **The Standard Option** calendar year deductible is $350 per person.
- **Under Standard Option Family Enrollment**, the calendar year deductible is considered satisfied for all family members when their combined covered expenses applied to the calendar year deductible reach $700.
- **The Standard Option deductible** is waived for the first four (4) professional office visits (see **Copayments** above) and preventive care.
- **The High Deductible Health Plan (HDHP)** calendar year deductible is $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment (each applies separately for services received from Plan providers and non-Plan providers). The Self and Family deductible can be satisfied by one or more family members.

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

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 for most services, except for infertility services that have a 50% coinsurance.

See *Your catastrophic protection out-of-pocket maximum* at the bottom of this page 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. *KPS does not require a referral for specialty care.* However, your choice of providers and hospitals affects the level of benefit coverage you receive, as well as your out-of-pocket costs.

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

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

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

- **Medical Emergency.** Emergency care is covered in full after you have met any applicable deductible, copayment, or coinsurance. If you are admitted to a non-Plan hospital as a result of your emergency, KPS reserves the right to arrange for your transportation to a Plan hospital (see Section 5(d), *Emergency services/accidents*, pages 60 and 119).
- **Services Not Available from Plan Providers/Facilities.** KPS has the right to determine whether care and services are, or are not, available from a Plan provider or facility. If you believe the care or service you require is not available from a Plan provider or facility, please contact KPS Customer Service at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 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 KPS determines that the care or service you require can only be obtained from a non-Plan provider, your care will be covered in full (if it is a medically necessary/covered benefit) after you have met any applicable deductible, copayment, or coinsurance.

Your catastrophic protection out-of-pocket maximum

For High Option, after your copayments and coinsurance total $5,000 per person or $5,000 per family enrollment in any calendar year, you do not have to pay any more for covered services, except the applicable charges for the following, which do not apply to your out-of-pocket maximum:

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

For Standard Option, after your deductible, copayments and coinsurance totals $5,000 per person or $5,000 per family enrollment in any calendar year, you do not have to pay any more for covered services, except the applicable charges for the following, which do not apply to your out-of-pocket maximum:

- 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, after your deductible, coinsurance, and pharmacy copayments total $4,000 per person or $8,000 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, except for the following, which do not apply to your out-of-pocket maximum:

- 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.

Right of Recovery

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

High and Standard Option Benefits

See page 16 for how our benefits changed this year. Page 151 and page 153 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711, or on our Web site at www.kpsfederal.com.

Each option offers unique features.

High Option	- No calendar year deductible - Preventive, basic, and major dental benefits - Alternative care provider coverage - $5 copayment for generic drugs
Standard Option	- First four (4) professional office visits (first 4 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) are covered with only a $15 copayment and no deductible - Preventive dental benefit - Alternative care provider coverage - $10 copayment for generic drugs

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option - We have no calendar year deductible.**
- **Under Standard Option** - The calendar year deductible is: $350 per person ($700 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.
- **For the non-Plan provider benefit see Section 5(i), *Point of Service (POS) benefits*, page 80.**

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	**High Option**	**Standard Option**
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion Note: Under High Option, you pay a copayment for office visits billed with codes corresponding to these services. Example for Standard Option: • Your first visit of the year is with a primary care doctor; you pay $15. • Your second visit of the year is with a chiropractor; you pay $15. • Your third visit of the year is with a physical therapist; you pay $15. • Your fourth visit of the year is with a behavioral health professional; you pay $15. • Starting with your fifth professional office visit, and for all additional office visits, you will pay the applicable deductible and 20% coinsurance.	$30 copayment per office visit Note: Copayment applies only to procedures done by provider (or provider's practitioner) scheduled for the visit; 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).	$15 copayment (no deductible) per visit for first four (4) professional office visits (first 4 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits Note: Copayment applies only to procedures done by provider (or provider's practitioner) scheduled for the visit; deductible and/or 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).
Professional services of physicians • During a hospital stay • In a skilled nursing facility • At home	20% of Plan allowance	20% of Plan allowance

Benefit Description	You pay After the calendar year deductible…	
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	20% of Plan allowance	20% of Plan allowance
Preventive care, adult	**High Option**	**Standard Option**
Routine screenings, such as: • Abdominal aortic aneurysm one time screening by ultrasonography for men age 65 to 75 with a history of smoking • Complete Blood Count, one annually • A fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides) for adults 20 and older • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening - Colonoscopy screening • Routine osteoporosis screening for women age 65 and older; beginning at age 60 for women at increased risk • Annual routine Prostate Specific Antigen (PSA) test for men age 40 and older • Annual routine mammogram for women age 35 and older • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) • One annual routine physical Well woman care including, but not limited to: • Routine pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections	Nothing	Nothing (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling - Contraceptive drugs - 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 See **Vision services (testing, treatment, and supplies)**, page 39, for annual routine eye exam benefits.	Nothing	Nothing (No deductible)
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.		
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All Charges*	*All Charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics • Initial exam of a newborn child covered under a family enrollment • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: • Screening examination of premature infants for Retinopathy of prematurity • Routine screening eye exams through age 17 to determine the need for vision correction (see *Vision services*, page 39, for diagnostic exams) • Routine screening hearing exams through age 17 to determine the need for hearing correction (see *Hearing services*, page 38, for diagnostic exams) • Examinations done on the day of immunizations (up to age 22)	Nothing	Nothing (No deductible)

Preventive care, children - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Preventive care, children (cont.)	**High Option**	**Standard Option**
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.		
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care by a physician, certified nurse midwife, or licensed midwife for: • Prenatal care (see *Preventive care, adult* page33) • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • Delivery (including home births) • Postnatal care Breastfeeding support, supplies and counseling for each birth. Note: 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 normal delivery; see Section 3 for other information. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a Cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. See Section 5(b), page 47, for circumcision benefits. • Dependent child – pregnancy, delivery, and care of newborn during mother's hospital stay is covered. For hospital/birthing center costs, see Section 5(c), page 57.	Nothing	Nothing (No deductible)
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*	*All Charges*

Benefit Description	You pay After the calendar year deductible…	
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary male sterilization (See Section 5(b), *Surgical procedures*, page 48)	20% of Plan allowance	20% of Plan allowance
• Voluntary female sterilization (see *Preventive care, adult*, page 33) • Contraceptive methods and counseling (see *Preventive care, adult*, page 33) - Surgically implanted contraceptives (see *Preventive care, adult*, page 33) - Injectable contraceptive drugs (such as Depo Provera) (see *Preventive care, adult*, page 33) - Intrauterine devices (IUDs) (see *Preventive care, adult*, page 33) - Diaphragms (see *Preventive care, adult*, page 33)	Nothing	Nothing (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization*	*All Charges*	*All Charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis & treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI)	50% of Plan allowance	50% of Plan allowance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Zygote transfer* - *Intrauterine insemination (IUI)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All Charges*	*All Charges*

Benefit Description	You pay After the calendar year deductible…	
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy injections	20% of Plan allowance	20% of Plan allowance
Allergy serum	Nothing	Nothing (No deductible)
Not covered: • *Provocative food testing and sublingual allergy desensitization.*	*All Charges*	*All Charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy – some types of chemotherapy require preauthorization. Your physician should call Customer Service at 1-800-552-7114 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*, page 49. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV supplies and medications that are self-administered, or when administered by a Home Health Agency, and antibiotic therapy; preauthorization required. If home health care services will be utilized, those services will be covered separately under the *Home health services* benefit on page 42. • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit and requires preauthorization. Note: We only cover GHT when we preauthroize the treatment. Your physician must contact MedImpact at 1-858-566-2727 for preauthorization before you begin treatment. MedImpact will ask for information to establish that the GHT is medically necessary. If preauthorization is not obtained before you begin treatment, we will only cover GHT services from the date the information is submitted. If treatment is not preauthorized, or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Other services* under *You need prior Plan approval for certain services* on page 20.	20% of Plan allowance	20% of Plan allowance

Benefit Description	You pay After the calendar year deductible…	
Neurodevelopmental therapies	**High Option**	**Standard Option**
Coverage under this benefit for the restoration and improvement of function in a neurodevelopmentally disabled child who is six (6) years of age or younger includes: • 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. No coverage is provided under this benefit for any person who is age seven (7) or older. Coverage under this benefit does not duplicate coverage for therapy services provided under any other benefit of this Plan.	20% of Plan allowance	20% of Plan allowance
Physical and occupational therapies	**High Option**	**Standard Option**
Up to a maximum 60 combined rehabilitation or habilitative visits per condition for the services of each of the following: • Qualified physical therapists • Occupational therapists 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*, page 38, and *Home health services*, page 42. For inpatient therapy benefit, see Section 5(c), page 56.	20% of Plan allowance	$15 copayment (no deductible) per visit for first four (4) professional office visits (first 4 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits Note: Copayment applies only to procedures done by provider (or provider's practitioner) scheduled for the visit; deductible and/or 20% coinsurace will apply to additional services ordered during the visit (e.g., lab and/or x-ray).
Cardiac rehabilitation is provided following procedures such as: • Heart transplant • Bypass surgery	20% of Plan allowance	20% of Plan allowance

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
• Myocardial infarction • Heart valve repair/replacement • Combined heart-lung transplant; • Angioplasty • Ischemic heart disease/coronary artery disease • Stable angina pectoris	20% of Plan allowance	20% of Plan allowance
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Reflexology* • *Rolfing*	*All Charges*	*All Charges*
Speech therapy	**High Option**	**Standard Option**
Licensed speech therapist Speech therapy is included in the maximum 60 combined visits per condition for physical and occupational therapies but is not limited to rehabilitation treatment. See *Physical and occupational therapies*, page 37. 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.	20% of Plan allowance	$15 copayment (no deductible) per visit for first four (4) professional office visits (first 4 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits Note: Copayment applies only to procedures done by provider (or provider's practitioner) scheduled for the visit; deductible and/or 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).
Hearing services (testing, treatment, and supplies)	**High Option**	**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*, page 33.	20% of Plan allowance	20% of Plan allowance

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

Benefit Description	You pay After the calendar year deductible…	
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• 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*, page 40.		
Not covered: • *Hearing services that are not shown as covered*	*All Charges*	*All Charges*
Vision services (testing, treatment, and supplies)	**High Option**	**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)	20% of Plan allowance	20% of Plan allowance
• Diagnostic eye exams provided by an optometrist or ophthalmologist to determine the need for vision correction for children through age 17. For routine screening eye exam benefit see *Preventive care, children*, page 33.	$30 copayment per exam Note: Copayment applies only to procedures done by provider (or provider's practitioner) scheduled for the visit; 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).	20% of Plan allowance
Annual routine eye exam for adults.	Nothing	Nothing (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* • *Diagnostic eye exams for adults*	*All Charges*	*All Charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See *Orthopedic and prosthetic devices*, page 40, for information on podiatric shoe inserts.	20% of Plan allowance	20% of Plan allowance
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*	*All Charges*	*All Charges*

Foot care - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Foot care (cont.)	**High Option**	**Standard Option**
• *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All Charges*	*All Charges*
Diabetic education, equipment and supplies	**High Option**	**Standard Option**
• Health Education and Training - Nutritional guidance • Medical Equipment - Dialysis equipment - Insulin pumps (requires prior authorization) - 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	20% of Plan allowance	20% of Plan allowance
Orthopedic and prosthetic devices	**High Option**	**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	20% of Plan allowance	20% of Plan allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy	20% of Plan allowance	20% of Plan allowance
Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical and anesthesia services*, page 47. 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*, page 56. Note: Orthopedic and prosthetic devices must be obtained from a Medicare certified provider. Purchases made through the Internet generally do not meet this reqirement and are not covered under this Plan. If you have questions about a provider you are considering, please contact KPS 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*	*All Charges*
Durable medical equipment (DME)	**High Option**	**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 Customer Service at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711. • Oxygen • Hospital beds • Wheelchairs • Crutches • Walkers • Motorized wheelchairs • Audible prescription reading device	20% of Plan allowance	20% of Plan allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
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 KPS before obtaining the equipment.		
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*	*All Charges*	*All Charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), 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 on page 36. Oxygen is covered separately under the *Durable medical equipment (DME)* benefit on page 41. 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*, page 37.	$30 copayment per visit Note: Copayment applies only to procedures done by provider (or provider's practitioner) scheduled for the visit; 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).	20% of Plan allowance per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All Charges*	*All Charges*

Benefit Description	You pay After the calendar year deductible…	
Chiropractic	**High Option**	**Standard Option**
• Up to 20 treatments per calendar year for manipulation of the spine and extremities	$30 copayment per treatment Note: Copayment applies only to procedures done by provider (or provider's practitioner) scheduled for the visit; 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).	$15 copayment (no deductible) per visit for first four (4) professional office visits (first 4 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits Note: Copayment applies only to procedures done by provider (or provider's practitioner) scheduled for the visit; deductible and/or 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).
Not covered: • *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application*	*All Charges*	*All Charges*
Alternative treatments	**High Option**	**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 • Naturopathic services	$30 copayment per treatment Note: Copayment applies only to procedures done by provider (or provider's practitioner) scheduled for the visit; 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).	$15 copayment (no deductible) per visit for first four (4) professional office visits (first 4 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits Note: Copayment applies only to procedures done by provider (or provider's practitioner) scheduled for the visit; deductible and/or 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).

Alternative treatments - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Alternative treatments (cont.)	**High Option**	**Standard Option**
Not covered: • *Herbs prescribed by an East Asian Medicine Practitioner (acupuncturist) or naturopath* • *Hypnotherapy* • *Biofeedback* • *Reflexology* • *Rolfing*	*All Charges*	*All Charges*
Educational classes and programs	**High Option**	**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 1-866-784-8454 toll-free or visit the Quit For Life® Web site 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.	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 registered dietitian 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) - Food allergies or intolerances - Obesity	20% of Plan allowance	20% of Plan allowance (No deductible)

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
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*	*All Charges*
Sleep disorders	**High Option**	**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. **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* on page 20. Surgical treatment includes all professional and facility fees related to the surgical treatment including pre- and post-operative care and complications.	20% of Plan allowance	20% of Plan allowance
Not covered: • *Any service not listed above for the purpose of studying, monitoring and/or treating sleep disorders.*	*All Charges*	*All Charges*

Benefit Description	You pay After the calendar year deductible…	
Temporomandibular joint (TMJ) disorders	**High Option**	**Standard Option**
Treatment of TMJ, includes surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy.	20% of Plan allowance	20% of Plan allowance
Not covered: • *Services primarily for cosmetic purposes* • *Related dental work*	*All Charges*	*All Charges*
Phenylketonuria (PKU) formulas	**High Option**	**Standard Option**
Special dietary formulas designed for use by those diagnosed with phenylketonuria.	Nothing	20% of Plan allowance (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 necessary.
- **Under High Option – We have no calendar year deductible.**
- **Under Standard Option** – The calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 and contact Customer Service at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 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 80.**

Benefit Description	You pay After the calendar year deductible…	
Surgical procedures	**High Option**	**Standard Option**
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 • Encoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*, page 48) • Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and prosthetic devices*, page 40, 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 from birth to one month old or as medically necessary	20% of Plan allowance	20% of Plan allowance

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Voluntary male sterilization (For female sterilization, See *Preventive care, adult*, page 33) • Treatment of burns • Surgical treatment (bariatric surgery) and all services associated with the surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards. 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 of the following comorbidities with a BMI of 35 or greater: sleep apnea, diabetes, hypertension, coronary artery disease or hyperlipidemia. 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* on page 20.	20% of Plan allowance	20% of Plan allowance
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Section 5(a), Foot care, page 39* • *Weight loss medications*	*All Charges*	*All Charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts	20% of Plan allowance	20% of Plan allowance

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
- Treatment of any physical complications, such as lymphedema - Breast prostheses and surgical bras and replacements (see Section 5(a), *Orthopedic and prosthetic devices*, page 40) 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.	20% of Plan allowance	20% of Plan allowance
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All Charges*	*All Charges*
Oral and maxillofacial surgery	**High Option**	**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.	20% of Plan allowance	20% of Plan allowance
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*	*All Charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services* on page 20. • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine	20% of Plan allowance	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • 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 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) **Blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. 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)	20% of Plan allowance	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - 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	20% of Plan allowance	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors - Waldenstrom's macroglobulinemia **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 - 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	20% of Plan allowance	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
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 - 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)	20% of Plan allowance	20% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- 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) - 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 - Scleroderma - Scleroderma-SSc (severe, progressive) National Transplant Program (NTP) *Note: 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.*	20% of Plan allowance	20% of Plan allowance
Not covered:	*All Charges*	*All Charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• *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*	*All Charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	20% of Plan allowance	20% of Plan allowance

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option – We have no calendar year deductible.**
- **Under Standard Option** – The calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to 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), pages 31 and 47.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 and contact Customer Service at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711 to be sure which services require preauthorization.
- **For non-Plan provider benefit see Section 5(i), *Point of Service (POS) benefits*, page 80.**

Benefit Description	You pay After the calendar year deductible...	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. 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	20% of Plan allowance	20% of Plan allowance

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• 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	20% of Plan allowance	20% of Plan allowance
Maternity delivery charges in a hospital or birthing center.	Nothing	Nothing (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*	*All Charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**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 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*, page 70.	20% of Plan allowance	20% of Plan allowance
Not covered: • *Take home medications*	*All Charges*	*All Charges*

Benefit Description	You pay After the calendar year deductible...	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
When appropriate, as determined by a Plan doctor and approved by KPS, we cover full-time skilled nursing care with no dollar or day limit and intensive physical and occupational therapies in a skilled nursing facility. Extended care benefits require preauthorization by our medical director.	20% of Plan allowance	20% of Plan allowance
Not covered: • *Custodial care*	*All Charges*	*All Charges*
Hospice care	**High Option**	**Standard Option**
Supportive and palliative care for a terminally ill member is covered up to six (6) months when services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness. Services include: • Medical care • Family counseling • Inpatient hospice benefits are available only when services are preauthorized a 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.	20% of Plan allowance	20% of Plan allowance
Not covered: • *Independent nursing, homemaker services*	*All Charges*	*All Charges*
Ambulance	**High Option**	**Standard Option**
Coverage for ambulance services includes: • Ground transportation • Air transportation up to a maximum $5,000 benefit per trip Air ambulance transportation is subject to review and approval by KPS. In cases where the patient's condition does not warrant air transportation, coverage will be based on the benefit for ground transportation. Note: If you are hospitalized in a non-Plan facility and Plan doctors believe care can be provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.	20% of Plan allowance	20% of Plan allowance

Ambulance - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Ambulance (cont.)	**High Option**	**Standard Option**
Not covered: • *The use of any type of ambulance transportation for personal convenience.*	*All Charges*	*All Charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option – We have no calendar year deductible.**
- **Under Standard Option** – The calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to almost all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9*, 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, KPS will work with your doctor to determine when and if it is medically feasible to transfer you to a Plan hospital. You will be transferred when medically feasible with any ambulance charges covered in full.

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

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

Follow-up care received from non-Plan providers and/or at a non-Plan facility when the care could be received from a Plan provider and/or at a Plan facility, will be covered at the Point of Service (POS) benefit level. See Section 5(i), *Point of Service (POS) benefits*, page 80.

Benefit Description	You pay After the calendar year deductible…	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$30 copayment Note: Copayment applies only to procedures done by the provider/practitioner seen during the visit; 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).	$15 copayment (no deductible) per visit for first four (4) professional office visits (first 4 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits Note: Copayment applies only to procedures done by the provider/practitioner seen during the visit; deductible and/or 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).
• Emergency care as an outpatient or inpatient at a hospital, including doctor's services Note: Under High Option, if the emergency results in admission to a hospital, inpatient services are subject to the hospital admission coinsurance of 20% and the emergency care copay is waived.	$150 copayment	20% of Plan allowance
Not covered: • *Elective care or non-emergency care*	*All Charges*	*All Charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$30 copayment Note: Copayment applies only to procedures done by the provider/practitioner seen during the visit; 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).	$15 copayment (no deductible) per visit for first four (4) professional office visits (first 4 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits

Emergency outside our service area - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Emergency outside our service area (cont.)	**High Option**	**Standard Option**
		Note: Copayment applies only to procedures done by the provider/practitioner seen during the visit; deductible and/or 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).
• Emergency care as an outpatient or inpatient at a hospital, including doctor's services Note: Under High Option, if the emergency results in admission to a hospital, inpatient services are subject to the hospital admission coinsurance of 20% and the emergency care copay is waived.	$150 copayment	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*	*All Charges*
Ambulance	**High Option**	**Standard Option**
Professional ambulance service when medically appropriate. • Ground transportation • Air transportation up to a maximum $5,000 benefit per trip 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 will be transferred when medically feasible with any ambulance charges covered in full. See Section 5(c), page 58, for non-emergency service.	20% of Plan allowance	20% of Plan allowance
Not covered: • *The use of any type of ambulance transportation for personal convenience.*	*All Charges*	*All Charges*

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

You need to get Plan approval (preauthorization) for inpatient services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option – We have no calendar year deductible.**
- **Under Standard Option** – The calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *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 abuse provider must obtain preauthorization by calling 1-800-223-6114 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."
  - Treatment plans for outpatient mental health services may be reviewed on a periodic basis to determine that they are covered and continue to be medically necessary.

    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 80.**

Benefit Description	You pay After the calendar year deductible…	
Professional services	**High Option**	**Standard Option**
When part of a treatment plan that we approve, we cover professional services by licensed professional mental health and substance abuse 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.	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 abuse practitioner • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • 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 abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$30 copayment per office visit Note: Copayment applies only to procedures done by provider (or provider's practitioner) scheduled for the visit; 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).	$15 copayment (no deductible) per visit for first four (4) professional office visits (first 4 visits include any combination of primary care; alternative care; physical, occupational, and speech therapy; mental health/substance abuse visits) Deductible and 20% coinsurance apply for all subsequent visits Note: Copayment applies only to procedures done by provider (or provider's practitioner) scheduled for the visit; deductible and/or 20% coinsurance will apply to additional services ordered during the visit (e.g., lab and/or x-ray).
Diagnostics	**High Option**	**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	20% of Plan allowance	20% of Plan allowance
Inpatient hospital or other covered facility	**High Option**	**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	20% of Plan allowance	20% of Plan allowance

Benefit Description	You pay After the calendar year deductible…	
Outpatient hospital or other covered facility	**High Option**	**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	20% of Plan allowance	20% of Plan allowance
Not Covered	**High Option**	**Standard Option**
• *Services that, upon review, are determined to be inappropriate to treat your condition or are Plan exclusions.*	*All Charges*	*All Charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart on page 68.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no calendar year deductible for this benefit.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9, *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 can write the prescription.

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 KPS Customer Service at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711; or our pharmacy benefit management company, MedImpact, toll-free at 1-800-788-2949.
- **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.

  For questions regarding the mail order program, contact KPS Customer Service at 360-478-6796 or toll-free at 1-800-552-7114.

  Order forms are available online at www.kpsfederal.com by clicking on Pharmacy/Mail Order Vendor, or through KPS Customer Service by calling 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711.

- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply per fill, except for certain Tier 1 and Tier 2 drugs, which may be dispensed on a 90-day supply basis with two (2) copayments. If a drug is a Tier 3 drug, you will pay the applicable copayment or coinsurance. Refills for any prescription drug cannot be obtained until at least 50% of the drug has been used. Drugs designated as specialty may be covered for up to a 30-day supply per fill.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a federally approved generic drug is available, and your physician has not specified "Dispense as Written" for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic in addition to applicable copayments.

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

- To obtain a 90-day supply of medications if you are called to active military duty.
- To obtain a 30-day supply of medications in times of national or other emergencies.

We have an open Drug Formulary. Drug Formulary (approved drug list) is defined as a list of preferred pharmaceutical products, supplies and devices developed and maintained by KPS. This means we classify MOST drugs into one of three “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 and some specialty drugs).

Because of their lower cost to you, we recommend that you ask your provider to prescribe Tier 1 or Tier 2 (preferred) drugs rather than Tier 3 (non-preferred) drugs. To order a Drug Formulary, call us at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711. You may also access the Drug Formulary on our Web site at www.kpsfederal.com.

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 Web site at www.kpsfederal.com.**

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

  MedImpact
  10680 Treena Street, 5th floor
  San Diego, CA 92131

For reimbursement of urgent or emergent prescription drugs, please provide 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:

KPS Claim Reimbursement
P.O. Box 34803
Seattle, WA 98124-1803

- **For additional information** on your pharmacy benefits, call Customer Service at 1-800-552-7114.
- **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 Web site at www.kpsfederal.com or call Customer Service toll-free at 1-800-552-7114 or MedImpact at 1-800-788-2949 prior to receiving services.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician 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 • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction limited to eight (8) pills per prescription per month • Prenatal vitamins during pregnancy • Preauthorized compounded drugs • Vitamin D for adults 65 and older	**Tier 1** $5 per prescription/refill $10 per 90-day supply **Tier 2 – Preferred** $25 per prescription/refill $50 per 90-day supply **Tier 3 – Non-Preferred** $50 per prescription/refill $100 per 90-day supply	**Tier 1** $10 per prescription/refill $20 per 90-day supply **Tier 2 – Preferred** $35 per prescription/refill $70 per 90-day supply **Tier 3 – Non-Preferred** $50 per prescription/refill $100 per 90-day supply
Women's contraceptive drugs and devices (see *Preventive care, adult* page 33) Note: Over-the-counter contraceptive drugs and devices, including emergency contraceptives, approved by the FDA require a written prescription by an approved provider.	Nothing	Nothing (No deductible)
Not covered: • *Drugs and supplies for cosmetic purposes* • *Non-prenatal vitamins, nutrients and food supplements even if a physician prescribes or administers them, except for Vitamin D as described above* • *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*	*All Charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
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, page 44).		

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*.
- **Under High Option,** the calendar year deductible of $25 per member ($50 maximum per family) is required for the services listed under “Basic dental care” and “Major dental care."
- After you have satisfied your annual deductible, **we pay 100% of the Fee Schedule Allowance for each procedure listed**. You are responsible for any amounts billed by your dentist that are greater than the KPS Fee Schedule Allowance.
- **For High Option, the annual maximum amount KPS will pay for all basic and major dental procedures combined is $1,000 per member (maximum does not apply to children through age 17 or preventive dental procedures). You are responsible for all charges once this maximum is met.**
- **Under Standard Option,** 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), page 56, for inpatient hospital benefits.
- The dental procedures listed below are not all-inclusive and are subject to change. Please call us at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 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 Desription	You Pay After the calendar year deductible . . .	
Accidental injury benefit	**High Option**	**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. Note: This benefit is not part of **Dental benefits**. The High Option $1,000 annual dental benefit maximum **does not** apply.	20% of Plan allowance	20% of Plan allowance

Dental benefits	We pay scheduled allowance (you pay all excess charges)		
Dental Services	**Codes**	**High Option**	**Standard Option**
PREVENTIVE DENTAL CARE (no deductible) • **Diagnostic**			
X-rays			
Intraoral - periapical first film	D0220	$20.00	$20.00
Intraoral – periapical each additional film	D0230	$19.00	$19.00
Intraoral – occlusal film	D0240	$41.00	$41.00
Bitewing X-rays – twice per calendar year			
Bitewing – single film	D0270	$20.00	$20.00
Bitewing – two films	D0272	$31.00	$31.00
Bitewing – four films	D0274	$45.00	$45.00
Full mouth or panorex X-rays - once every 3 calendar years			
Panoramic film	D0330	$77.00	$77.00
Intraoral - complete series (including bitewings)	D0210	$95.00	$95.00
Oral Exam			
Periodic oral exam – twice per calendar year	D0120	$41.00	$41.00
Limited oral evaluation – problem focused	D0140	$58.00	$58.00
Comprehensive oral evaluation	D0150	$57.00	$57.00
Pulp vitality tests	D0460	$38.00	$38.00
Emergency examinations	Varies	By Report	By Report
Prophylaxis (cleaning) – twice per calendar year			
Prophylaxis – through age 13	D1120	$51.00	$51.00
Prophylaxis – after age 13	D1110	$88.00	$88.00
Fluoride – twice per calendar year through age 17			
Topical application of fluoride (prophylaxis not included)	D1208	$32.00	$32.00
Other Preventive Services			
Application of sealants for permanent molars and bicuspids only (with a 3 year limitation per surface); sealant per tooth	D1351	$28.00	$28.00
Space Maintenance (Passive Appliances)			
Space maintainer – fixed – unilateral	D1510	$192.00	No benefit
BASIC DENTAL CARE • **Restorative** **Restoration of carious (decayed) teeth to a state of functional acceptability utlizing filling materials, such as amalgam, silicate or plastic.**			
Amalgam restorations (including polishing)			
Amalgam - one surface, permanent	D2140	$77.00	No benefit

Dental Services - continued on next page

Dental benefits	We pay scheduled allowance (you pay all excess charges)		
Dental Services (cont.)	**Codes**	**High Option**	**Standard Option**
Amalgam - two surfaces, permanent	D2150	$104.00	No benefit
Amalgam - three surfaces, permanent	D2160	$126.00	No benefit
Amalgam - four or more surfaces, permanent	D2161	$152.00	No benefit
Resin-based composite restorations			
Resin-based composite - one surface anterior	D2330	$87.00	No benefit
Resin-based composite - two surfaces, anterior	D2331	$121.00	No benefit
Resin-based composite - three surfaces, anterior	D2332	$152.00	No benefit
Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D2335	$186.00	No benefit
Resin-based composite - one surface, posterior	D2391	$108.75	No benefit
Resin-based composite - two surfaces, posterior	D2392	$146.00	No benefit
Resin-based composite - three or more surfaces, posterior	D2393	$190.00	No benefit
Resin-based composite - four or more surfaces, posterior	D2394	$232.50	No benefit
Inlay/Onlay Restorations			
Onlay-metallic-four or more surfaces	D2544	$391.00	No benefit
Other restorative services			
Sedative filling	D2940	$40.00	No benefit
• **Oral Surgery** **Removal of teeth and minor surgical procedures, including surgical and non-surgical extractions, preparation of the alveolar ridge and soft tissues of the mouth for insertion of dentures and general anesthesia when administered in connection with covered oral surgery procedures.**			
Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care)			
Coronal remnants - deciduous tooth	D7111	$292.00	No benefit
Root removal - exposed roots	D7140	$248.75	No benefit
Surgical Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care)			
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	D7210	$199.00	No benefit
Removal of impacted tooth - soft tissue	D7220	$261.00	No benefit
Removal of impacted tooth - partially bony	D7230	$273.00	No benefit
Removal of impacted tooth - completely bony	D7240	$289.00	No benefit
Removal of impacted tooth - completely bony, with unusual surgical complications	D7241	$342.00	No benefit
Surgical removal of residual tooth roots (cutting procedure)	D7250	$178.00	No benefit
Alveoloplasty - surgical preparation of the ridge for dentures			
Alveoloplasty in conjunction with extractions - per quadrant	D7310	$141.00	No benefit

Dental Services - continued on next page

Dental benefits	We pay scheduled allowance (you pay all excess charges)		
Dental Services (cont.)	**Codes**	**High Option**	**Standard Option**
• **Periodontics** **Surgical and non-surgical procedures for treatment of the tissues supporting the teeth, including root planing, subgingival curettage, gingivectomy and minor adjustments to occlusion such as smoothing of teeth or reducing cusps.**			
Surgical services (including usual postoperative care)			
Gingivectomy or gingivoplasty - per quadrant	D4210	$472.00	No benefit
Gingivectomy or gingivoplasty - per tooth	D4211	$127.00	No Benefit
Gingival flap procedure, including root planing - per quadrant	D4240	$419.00	No benefit
Clinical crown lengthening - hard tissue	D4249	$647.00	No benefit
Osseous surgery (including flap entry & closure) per quadrant	D4260	$830.00	No benefit
Bone replacement graft - first site in quadrant	D4263	$385.00	No benefit
Bone replacement graft - each additional site in quadrant	D4264	$182.00	No benefit
Pedicle soft tissue graft procedure	D4270	$664.00	No benefit
Free soft tissue graft procedure (including donor site surgery)	D4271	$491.00	No benefit
Subepithelial connective tissue graft procedure (including donor site surgery)	D4273	$728.00	No benefit
Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	D4274	$206.00	No benefit
Non-Surgical Periodontal Service			
Periodontal scaling and root planing, per quadrant	D4341	$131.00	No benefit
Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis	D4355	$109.00	No benefit
Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	D4381	$71.00	No benefit
Other Periodontal Services			
Periodontal maintenance procedures (following active therapy)	D4910	$106.00	No benefit
• **Endodontics** **Procedures for pulpal and root canal therapy, including pulp exposure treatment, pulpotomy and apicoectomy**			
Pulp Capping			
Pulp cap - direct (excluding final restoration)	D3110	$60.00	No benefit
Pulp cap - indirect (excluding final restoration)	D3120	$39.00	No benefit
Pulpotomy			
Therapeutic pulpotomy (excluding final restoration)	D3220	$82.00	No benefit

Dental Services - continued on next page

Dental benefits	We pay scheduled allowance (you pay all excess charges)		
Dental Services (cont.)	**Codes**	**High Option**	**Standard Option**
Endodontic Therapy on Primary Teeth			
Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	D3240	$127.00	No benefit
Endodontic Therapy (including treatment plan, clinical procedures and follow-up care)			
Anterior (excluding final restoration)	D3310	$495.00	No benefit
Bicuspid (excluding final restoration)	D3320	$525.00	No benefit
Molar (excluding final restoration)	D3330	$706.00	No benefit
Apicoectomy/Periradicular Services			
Apicoectomy/periradicular surgery - anterior	D3410	$540.00	No benefit
Apicoectomy/periradicular surgery - bicuspid (first root)	D3421	$762.00	No benefit
Apicoectomy/periradicular surgery - molar (first root)	D3425	$667.00	No benefit
Apicoectomy/periradicular surgery (each additional root)	D3426	$222.00	No benefit
Retrograde filling - per root	D3430	$163.00	No benefit
MAJOR DENTAL CARE • **Crowns - Single Restorations Only**			
Crown - resin (laboratory)	D2710	$167.00	No benefit
Crown - porcelain/ceramic substrate	D2740	$465.00	No benefit
Crown - porcelain fused to high noble metal	D2750	$414.00	No benefit
Crown - porcelain fused to predominantly base metal	D2751	$397.00	No benefit
Crown - porcelain fused to noble metal	D2752	$415.00	No benefit
Crown - 3/4 cast high noble metal	D2780	$393.00	No benefit
Crown - full cast high noble metal	D2790	$411.00	No benefit
Crown - full cast predominantly base metal	D2791	$381.00	No benefit
Crown - full cast noble metal	D2792	$389.00	No benefit
• **Other Restorative Services**			
Recement crown	D2920	$59.00	No benefit
Prefabricated stainless steel crown - primary tooth	D2930	$133.00	No benefit
Prefabricated stainless steel crown - permanent tooth	D2931	$180.00	No benefit
Core buildup, including any pins	D2950	$95.00	No benefit
Pin retention - per tooth, in addition to restoration	D2951	$31.00	No benefit
Cast post and core in addition to crown	D2952	$76.00	No benefit
Prefabricated post and core in addition to crown	D2954	$151.00	No benefit
Crown repair	D2980	By Report	No benefit
• **Prosthodontics** **Complete Dentures (including routine post-delivery care)**			

Dental Services - continued on next page

Dental benefits	We pay scheduled allowance (you pay all excess charges)		
Dental Services (cont.)	**Codes**	**High Option**	**Standard Option**
Complete denture - maxillary	D5110	$520.00	No benefit
Complete denture - mandibular	D5120	$460.00	No benefit
Partial Dentures (including routine post-delivery care)			
Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5214	$537.00	No benefit
Adjustments to Dentures			
Adjust complete denture - mandibular	D5411	$34.00	No benefit
Repairs to Partial Dentures			
Repair resin denture base	D5610	$48.00	No benefit
Repair or replace broken clasp	D5630	$89.00	No benefit
Replace broken teeth - per tooth	D5640	$58.00	No benefit
Add tooth to existing partial denture	D5650	$79.00	No benefit
Denture Reline Procedures			
Reline complete maxillary denture	D5750	$128.00	No benefit
Other Removable Prosthetic Services			
Tissue conditioning, maxillary	D5850	$32.00	No benefit
Tissue conditioning, mandibular	D5851	$32.00	No benefit
• **Prosthodontics, Fixed** **Fixed Partial Denture Pontics**			
Pontic - cast high noble metal	D6210	$415.00	No benefit
Pontic - cast predominantly base metal	D6211	$104.00	No benefit
Pontic - porcelain fused to high noble metal	D6240	$407.00	No benefit
Pontic - porcelain fused to predominantly base metal	D6241	$375.00	No benefit
Pontic - porcelain fused to noble metal	D6242	$386.00	No benefit
Fixed Partial Denture Retainers - Inlays/Onlays			
Retainer - cast metal for resin bonded fixed prosthesis	D6545	$217.00	No benefit
Inlay - metallic - three or more surfaces	D6603	$379.00	No benefit
Crown - porcelain fused to high noble metal	D6750	$405.00	No benefit
Crown - porcelain fused to predominantly base metal	D6751	$403.00	No benefit
Crown - porcelain fused to noble metal	D6752	$428.00	No benefit
Crown - full cast high noble metal	D6790	$415.00	No benefit
Other Fixed Partial Denture Services			
Precision attachment	D6950	$268.00	No benefit
• **Adjunctive General Services** **Miscellaneous Treatment**			

Dental Services - continued on next page

Dental benefits	We pay scheduled allowance (you pay all excess charges)		
Dental Services (cont.)	**Codes**	**High Option**	**Standard Option**
Palliative (emergency) treatment of dental pain - minor procedure	D9110	$84.00	No benefit
Anesthesia			
Trigeminal division block anesthesia	D9212	$73.00	No benefit
General anesthesia - first 30 minutes	D9220	$282.00	No benefit
General anesthesia - each additional 15 minutes	D9221	$77.00	No benefit
Intravenous sedation/analgesia - first 30 minutes	D9241	$171.00	No benefit
Miscellaneous Services			
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	D9310	$211.00	No benefit
Office visit for observation (during regularly scheduled hours) - no other services performed	D9430	$71.00	No benefit
Application of desensitizing medicament	D9910	$36.00	No benefit

Dental benefits	You pay
Not covered:	
• *Appliances or restorations necessary to correct vertical dimensions or restore the occlusion* • *Restoration on the same surface(s) of the same tooth within a two-year period* • *Ridge extensions for insertion of dentures* • *Major surgical procedures (e.g., mandibular osteotomy)* • *Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting* • *Root planing and/or subgingival curettage more than once in a 12-month period* • *Root canal treatment on the same tooth more than once in a two-year period* • *Replacement of a space maintainer, previously covered by the Plan* • *Procedures, appliances or restorations primarily for cosmetic purposes or night guards* • *Orthodontic services* • *Procedures associated with teeth lost before you became enrolled in this Plan* • *Temporary dentures* • *Surgical placement or removal of implants* • *Charges or expenses for hospitalization* • *Any condition or injury which is work related* • *Dental care which does not meet the standards of dental practice as accepted by the American Dental Association* • *Charges for appointments not kept or for completion of claim forms* • *Expenses related to service or supplies of the type normally intended for sport or home use* • *Charges for replacement of bridges or dentures which have been lost, misplaced or stolen* • *Initial placement of a complete or partial denture or for fixed bridgework to replace one or more natural tooth/teeth lost before you became enrolled in this Plan* • *Any charge in excess of the Fee Schedule Allowance for the least expensive alternative service or material consistent with adequate dental care, when such alternative service or material is customarily provided* • *Analgesics (such as nitrous oxide), or any other euphoric drugs* • *Charges for dental devices performed by a dental mechanic or other type of dental technician who is not a dentist; this exclusion does not apply to a denturist when services are performed within the lawful scope of the denturist's license* • *Dental services started prior to the date the member enrolled in this Plan* • *Dental services not on our schedule allowance list* **NOTE: The procedures and scheduled allowances listed in this brochure are intended as a summary of the most common procedures, not an exhaustive list. For questions regarding other specific procedures and scheduled allowances that fall under any of the preventive dental care or basic dental care procedures listed in this section, please call our Customer Service department at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711.**	*All Charges*

Dental benefits	Major Dental Care Limitations
Restorative	
Restoration of decayed teeth using crowns, inlays or onlays frabicated from gold, porcelain, plastic, gold substitute castings or combinations thereof	Crowns, inlays or onlays on the same tooth are covered once every five (5) calendar years
Prosthodontics	
Full -, immediate- and over-dentures	Root canal therapy performed in conjunction with over-dentures is limited to two (2) teeth per arch. The cost of personalized restorations or specialized techniques is reimbursed at the appropriate fee schedule allowance for full-, immediate- or over-dentures.
Partial dentures	Covered up to the KPS allowance for cast chrome and acrylic partial dentures only.
Denture adjustments and realignment	Adjustments and realignments are covered if done more than six (6) months following the initial placement. Subsequent alignments are covered once every calendar year.
Implants	Implants are not covered. However, the cost of the appliance that is constructed on the implant is reimbursed at the appropriate fee schedule allowance for full or partial dentures.
Adjustment or repair of an existing prosthetic device	Replacement of an existing prosthetic device is covered only if the device is unserviceable and cannot be made serviceable. Prosthetic devices are covered only if five (5) calendar years have elapsed since the prior provision of such a device.

Section 5(h). Special features

Feature	Description
Flexible benefits option	In certain cases, KPS, at its sole discretion, may choose to authorize coverage for benefits or services that are not otherwise included as covered under this Plan. Such authorization is done on a case-by-case basis if a particular benefit or service is judged to be medically necessary, beneficial, and cost effective. However, our decision to authorize services in one instance does not commit us to cover the same or similar services for you in other instances or to cover the same or similar services in any other instance for any other enrollee. Our decision to authorize services does not constitute a waiver of our right to enforce the provisions, limitations, and exclusions of this Plan. 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).
Services for deaf and hearing impaired	KPS utilizes the following Washington state relay numbers: 1-800-833-6388 and 711
Travel benefit/services overseas	**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: KPS Health Plans P.O. Box 339 Bremerton, WA 98337-0039 We will do the translation and currency conversion for you. You may obtain the Overseas Claim Form by calling KPS toll-free at 1-800-552-7114 or from our Web site at www.kpshealthplans.com, Members/Forms and Information. **Note: You are responsible for the cost of all non-urgent/emergent care received outside of Washington state.**

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

Important things you should keep in mind about these benefits:

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

- Non-urgent/emergent care received outside our service area (i.e., Washington state).
- Non-emergency prescription drugs received from a non-Plan pharmacy (see Section 5(f), *Prescription drug benefits*, page 66, for details).
- 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 KPS.

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, KPS will:

- Determine what our allowable amount would have been for a Plan provider*.
- Apply your appropriate cost-sharing (i.e., deductible and/or copayment) to the allowed amount.
- Pay the non-Plan provider 60% of the allowed amount balance.
- The non-Plan provider may balance bill you for the difference between what KPS pays and the original charges.

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

High Deductible Health Plan Benefits

See page 16 for how our benefits changed this year and page 155 for a benefits summary.

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Section 5. High Deductible Health Plan Benefits Overview

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

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711; or visit our Web site at www.kpsfederal.com.

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

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. Your full annual HRA credit will be available on your effective date of enrollment.

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, KPS must receive an HSA Eligibility Worksheet from you** (the worksheet is sent to you with your new member materials or is available on our Web site at www.kpsfederal.com). If you are eligible for an HSA, in addition to the worksheet, you must complete the HSA enrollment process with Wells Fargo.

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 97 - 128. 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 93, *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 106, 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 abuse benefits
- Prescription drug benefits
- Accidental dental injury benefits

- **Out-of-network services**

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

When you use non-Plan providers, your benefits are significantly less than if you use Plan providers. KPS will pay 60% of our allowed amount 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 KPS. 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:

- Non-urgent/emergent care received outside our service area (i.e., Washington state).
- Non-emergency prescription drugs received from a non-Plan pharmacy (see Section 5(f), *Prescription drug benefits*, page 124, for details).
- 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 KPS.

Emergency benefits
Emergency care is always payable at the in-network benefit level. Please see Section 5(d), *Emergency services/accidents,* page 119, for benefit details.

- **Savings**

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 89 for more details).

Health Savings Accounts (HSA)s

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 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 2014, 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 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 $3,300 for an individual and $6,550 for a family. See maximum contribution information on page 88. 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, KPS will send you an HSA Eligibility Worksheet and instructions on how to enroll in an HSA with Wells Fargo. The worksheet is sent to you with your new member materials or is available on our Web site at www.kpsfederal.com. 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, KPS must receive the HSA Eligibility Worksheet. In addition to the worksheet, you must complete the HSA enrollment process with Wells Fargo.

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

HSA features include:

- Your HSA is administered by Wells Fargo Bank.
- Your contributions to the HSA are tax deductible.
- 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 Web site at www.kpsfederal.com.

In 2014, we will give you an HRA credit of $750 per year for a Self Only enrollment and $1,500 per year for a 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 HealthSmart Benefit Solutions.

- Your entire HRA credit is funded from your HDHP enrollment effective date to the end of the Plan year.

  NOTE: If your enrollment in this HDHP becomes effective other than the first day of a month, your HRA credit will be prorated based on 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 credits carryover 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 $4,000 per person or $8,000 per family enrollment (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*, page 26, for more details.

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

  HDHP Section 5(i), page 130, describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with Wells Fargo Bank, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	HealthSmart Benefit Solutions is the HRA fiduciary for this Plan.
Fees	Set-up fee and $3.75 per month administrative fee charged by the fiduciary is paid by the Plan.	Set-up fee 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.**	The entire amount of your HRA will be available to you upon your enrollment and prorated based on how long you are enrolled. **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.**

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
• **Self Only enrollment**	For 2014, a monthly premium pass through of $62.50 will be made by the HDHP directly into your HSA each month.	For 2014, your HRA annual credit is $750 (based on your HDHP enrollment effective date).
• **Self and Family enrollment**	For 2014, a monthly premium pass through of $125 will be made by the HDHP directly into your HSA each month.	For 2014, your HRA annual credit is $1,500 (based on your HDHP enrollment effective date).
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 $3,300 for an individual and $6,550 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).	The full HRA credit will be available, subject to proration, on the effective date of enrollment. 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.**

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
• **Contributions/ credits (cont.)**	HSAs earn tax-free interest (interest does not affect your annual maximum contribution). Catch-up contributions are discussed on page 91.	
• **Self Only enrollment**	You may make an annual maximum contribution of $2,550 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 $5,050 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: • Health Savings Account debit Visa® card • Withdrawal form	You can access your HRA by the following methods: • Benefits Debit MasterCard® • 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 90, 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.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
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 Wells Fargo. • You return the HSA Eligibility Worksheet to the Plan, confirming you meet the HSA eligibility requirements. • You enroll in an HSA with Wells Fargo. • The Plan confirms your HSA enrollment with Wells Fargo. • 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.**	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 HealthSmart Benefit Solutions and establishes your HRA account. The entire amount of your HRA will be available to you the first of the month following the Plan's receipt of the HSA Eligibility Worksheet. **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 84 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 Wells Fargo Bank toll-free at 1-866-884-7374 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 Web site at www.ustreas.gov/offices/public-affairs/hsa.

- **If you die**

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

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, **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 1-800-829-3676, or visit the IRS Web site 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 87, 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 HealthSmart Benefit Solutions toll-free at 1-800-503-9098 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 96.

Benefit Description	You pay
Preventive care, adult	
Routine screenings, such as: • Abdominal aortic aneurysm one time screening by ultrasonography for men age 65 to 75 with a history of smoking • Complete Blood Count, one annually • A fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides) for adults 20 and older • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening - Colonoscopy screening • Routine osteoporosis screening for women age 65 and older; beginning at age 60 for women at increased risk • Annual routine Prostate Specific Antigen (PSA) test for men age 40 and older • Annual routine mammogram for women age 35 and older • Adult routine immunizations endorsed by the Center for Disease Control and Prevention (CDC) • One annual routine physical • One annual routine eye exam Well woman care; including, but not limited to: • Routine pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling - Contraceptive drugs - Surgically implanted contraceptives - Injectable contraceptive drugs (such as Depo Provera) - Intrauterine devices (IUDs) - Diaphragms • Screening and counseling for interpersonal and domestic violence • Routine prenatal care • Female voluntary sterilization	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All Charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics • Initial exam of a newborn child covered under a family enrollment • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Screening examination of premature infants for Retinopathy of prematurity - Routine screening eye exams through age 17 to determine the need for vision correction (see *Vision services*, page 102, for diagnostic exams) - Routine screening hearing exams through age 17 to determine the need for hearing correction (see *Hearing services*, page 102, for diagnostic exams) - Examinations done on the day of immunizations (up to age 22)	Nothing
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	
Not covered: • *Immunizations, boosters, and medications for travel.*	*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

Dental Services - continued on next page

Dental preventive care		
Dental Services (cont.)	**Codes**	**We Pay Scheduled Allowance (you pay all excess charges)**
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); 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 Customer Service department at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 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 93) and is not subject to the calendar year deductible.
- The deductible is $1,500 per person or $3,000 per family enrollment (each applies separately for services received from Plan providers and non-Plan providers). The family deductible can be satisfied by one or more family members. The deductible applies to all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments, and deductibles total $4,000 per person or $8,000 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).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *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 or $3,000 per family enrollment.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	**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 and $3,000 for Self and Family enrollment (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The Self and Family deductible can be satisfied by one or more family members. 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 • During a hospital stay • In a skilled nursing facility • At home	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
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: 40% of Plan allowance

Benefit Description	You pay After the calendar year deductible…
Maternity care	
Complete maternity (obstetrical) care by a physician, certified nurse midwife, or licensed midwife for: • Prenatal care (see *Preventive care, adult* page 93) • Delivery (including home births) • Postnatal care Note: Here are some things to keep in mind: • You do not need to preauthorize your normal delivery; see Section 3 for other information. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a Cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. See Section 5(b), page 108, for circumcision 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.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
• Breastfeeding support, supplies and counseling for each birth • Screening for gestational diabetes for pregnant women between 24 - 28 weeks gestation or first prenatal visit for women at a high risk.	In-network: Nothing (No deductible) Out-of-network: 40% of Plan allowance
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), page 108, for surgical procedures)
• Voluntary female sterilization (see *Preventive care, adult* page 93)
• Contraceptive methods and counseling (see *Preventive care, adult* page 93)
  - Surgically implanted contraceptives (see *Preventive care, adult* page 93)
  - Injectable contraceptive drugs (such as Depo Provera) (see *Preventive care, adult* page 93)
	In-network: 20% of Plan allowance
	
	Out-of-network: 40% of Plan allowance

Family planning - continued on next page

Benefit Description	You pay After the calendar year deductible…
Family planning (cont.)	
- Intrauterine devices (IUDs) (see *Preventive care, adult* page 93) - Diaphragms (see *Preventive care, adult* page 93)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
Not covered: • *Reversal of voluntary surgical sterilization*	*All Charges*
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI)	50% of Plan allowance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Zygote transfer* - *Intrauterine insemination (IUI)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All Charges*
Allergy care	
• Testing and treatment • Allergy injections	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
Allergy serum	Nothing
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 Customer Service at 1-800-552-7114 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*, page 110. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	
• Intravenous (IV)/Infusion Therapy – Home IV supplies and medications that are self-administered, or when administered by a Home Health Agency, and antibiotic therapy; preauthorization required. If home health care services will be utilized, those services will be covered separately under the *Home health services* benefit on page 105. • 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 contact MedImpact at 1-858-566-2727 for preauthorization before you begin treatment. MedImpact will ask for information to establish that the GHT is medically necessary. If preauthorization is not obtained before you begin treatment, we will only cover GHT services from the date the information is submitted. If treatment is not preauthorized, or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Other services* under *You need prior Plan approval for certain services* on page 20.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
Neurodevelopmental therapies	
Coverage under this benefit for the restoration and improvement of function in a neurodevelopmentally disabled child who is six (6) years of age or younger includes: • 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. No coverage is provided under this benefit for any person who is age seven (7) or older. 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

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies	
Up to a maximum 60 combined rehabilitation or habilitative visits per condition for the services of each of the following: • Qualified physical therapists • Occupational therapists 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*, page 105. For inpatient therapy benefit, see Section 5(c), page 116.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
Cardiac rehabilitation is provided 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
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Reflexology* • *Rolfing*	*All Charges*
Speech therapy	
Licensed speech therapist Speech therapy is included in the maximum 60 combined visits per condition for physical and occupational therapies but is not limited to rehabilitation treatment. See *Physical and occupational therapies* above. 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.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance

Benefit Description	You pay After the calendar year deductible…
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, page 94*.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
• 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, page 103*.	
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 children through age 17. For routine screening eye exam benefits see *Preventive care, adult, see page 93* and *Preventive care, children*, see page 94.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
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* • *Diagnostic eye exams for adults*	*All Charges*
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
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	
• Health Education and Training - Nutritional guidance • Medical Equipment - Dialysis equipment - Insulin pumps (requires prior authorization) - 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
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 • 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*, page 108. 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*, page 116.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	
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 ar not covered under this Plan. If you have questions about a provider you are considering, please contact KPS 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 Customer Service at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711. • Oxygen • Hospital beds • Wheelchairs • Crutches • Walkers • Motorized wheelchairs • Audible prescription reading device 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 KPS before obtaining the equipment.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
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*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), master of social work (M.S.W.), or home health aide. Up to two hours per visit. • Services include oxygen therapy, intravenous therapy, and assistance with medications. IV therapy supplies and medications are covered separately under the *Treatment therapies* benefit on page 99. Oxygen is covered separately under the *Durable medical equipment (DME)* benefit described on page 104. 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*, page 101.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
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	
• 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
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 • Naturopathic services	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
Not covered: • *Herbs prescribed by an East Asian Medicine Practitioner (acupuncturist) or naturopath* • *Hypnotherapy*	*All Charges.*

Alternative treatments - continued on next page

Benefit Description	You pay After the calendar year deductible…
Alternative treatments (cont.)	
• *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 1-866-784-8454 toll-free or visit the Quit For Life® Web site 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 registered dietitian 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) - Food allergies or intolerances - Obesity	Nothing
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*

Benefit Description	You pay After the calendar year deductible…
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. **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* on page 20. 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
Not covered: • *Any service not listed above for the purpose of studying, monitoring and/or treating sleep disorders.*	*All Charges*
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
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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 and contact Customer Service at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 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*, page 109) • Insertion of internal prosthetic devices (See Section 5(a), *Orthopedic and prosthetic devices*, page 103, 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 from birth to one month old or as medically necessary • Voluntary male sterilization (For female sterilization, see *Preventive care, adult* page 93.)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
• Treatment of burns • Surgical treatment (bariatric surgery) and all services associated with the surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards. 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 of the following comorbidities with a BMI of 35 or greater: sleep apnea, diabetes, hypertension, coronary artery disease or hyperlipidemia. 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* on page 20.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Section 5(a), Foot care, page 102* • *Weight loss medications*	*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: - 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,* page 103) 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
Not covered:	*All Charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	
• *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All Charges*
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
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* on page 20. • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • 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

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
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) **Blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. 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 - 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)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- 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 **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 - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- 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 **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 - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- 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) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis - Scleroderma - Scleroderma-SSc(severe, progressive) National Transplant Program (NTP)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
Note: 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*
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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9, *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), pages 97 and 108.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 and contact Customer Service at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 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 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, maternity, birthing centers and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	
• 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
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 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
Not covered: • *Take home medications*	*All Charges*
Extended care benefits/Skilled nursing care facility benefits	
When appropriate, as determined by a Plan doctor and approved by KPS, we cover full-time skilled nursing care with no dollar or day limit and intensive physical and occupational therapies in a skilled nursing facility. Extended care benefits require preauthorization by our medical director.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
Not covered: • *Custodial care*	*All Charges*

Benefit Description	You Pay After the calendar year deductible...
Hospice care	
Supportive and palliative care for a terminally ill member is covered up to six (6) months when services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness. 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
Not covered: • *Independent nursing, homemaker services*	*All Charges*
Ambulance	
Coverage for ambulance services includes: • Ground transportation • Air transportation up to a maximum $5,000 benefit per trip Air ambulance transportation is subject to review and approval by KPS. In cases where the patient's condition does not warrant air transportation, coverage will be based on the benefit for ground transportation.	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 will be transferred 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 and $3,000 for Self and Family enrollment (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9, *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, KPS will work with your doctor to determine when and if it is medically feasible to transfer you to a Plan hospital. You will be transferred when medically feasible with any ambulance charges covered in full.

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

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

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

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	
• 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 up to a maximum $5,000 benefit per trip 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 will be transferred when medically feasible with any ambulance charges covered in full. See Section 5(c), page 118, 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 abuse benefits

You need to get Plan approval (preauthorization) for inpatient services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment (each applies separately for services received from Plan providers and non-Plan providers). The Self and Family deductible can be satisfied by one or more family members. 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 abuse provider must obtain preauthorization by calling 1-800-223-6114 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."
  - Treatment plans for outpatient mental health services may be reviewed on a periodic basis to determine that they are covered and continue to be medically necessary.

    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	
When part of a treatment plan that we approve, we cover professional services by licensed professional mental health and substance abuse 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 abuse practitioner • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • 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 abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
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
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	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance
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

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.*	*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 126.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9, *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 can write your prescription.

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 KPS Customer Service at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711; or our pharmacy benefit management company, MedImpact, toll-free at 1-800-788-2949.
- **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.

  For questions regarding the mail order program, contact KPS Customer Service at 360-478-6796 or toll-free at 1-800-552-7114.

  Order forms are available online at www.kpsfederal.com by clicking on Pharmacy/Mail Order Vendor, or through KPS Customer Service by calling 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711.

- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply per fill, except for certain Tier 1 and Tier 2 drugs, which may be dispensed on a 90-day supply basis with two (2) copayments. If a drug is a Tier 3 drug, you will pay the applicable copayment or coinsurance. Refills for any prescription drug cannot be obtained until at least 50% of the drug has been used. Drugs designated as specialty may be covered for up to a 30-day supply per fill.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a federally approved generic drug is available, and your physician has not specified "Dispense as Written" for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic in addition to applicable copyaments.

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

- To obtain a 90-day supply of medications if you are called to active military duty.
- To obtain a 30-day supply of medications in times of national or other emergencies.

We have an open Drug Formulary. Drug Formulary (approved drug list) is defined as a list of preferred pharmaceutical products, supplies and devices developed and maintained by KPS. This means we classify MOST drugs into one of three "tier" categories:

- Tier 1 generally includes generic drugs, but may include some brand formulary or preffered 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 and some specialty drugs).

Because of their lower cost to you, we recommend that you ask your provider to prescribe Tier 1 or Tier 2 (preferred) drugs rather than Tier 3 (non-preferred) drugs. To order a Drug Formulary, call us at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711. You may also access the Drug Formulary on our Web site at www.kpsfederal.com.

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 Web site at www.kpsfederal.com.**

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

MedImpact
10680 Treena Street, 5th floor
San Diego, CA 92131

For reimbursement of urgent or emergent prescription drugs, please provide 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:

KPS Claim Reimbursement
P.O. Box 34803
Seattle, WA 98124-1803

- **For additional information** on your pharmacy benefits, call Customer Service at 1-800-552-7114.
- **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 Web site at www.kpsfederal.com or call Customer Service toll-free at 1-800-552-7114 or MedImpact at 1-800-788-2949 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 Plan 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 • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction limited to eight (8) pills per prescription per month • Prenatal vitamins during pregnancy • Preauthorized compounded drugs • Vitamin D for adults 65 and older	**Tier 1** $10 per prescription/refill $20 per 90-day supply **Tier 2 – Preferred** $35 per prescription/refill $70 per 90-day supply **Tier 3 – Non-Preferred** $50 per prescription/refill $100 per 90-day supply
Women's contraceptive drugs and devices (*see Preventive care, adult* page 93) Note: Over-the-counter contraceptive drugs and devices, including emergency contraceptives, approved by the FDA require a written prescription by an approved provider.	Nothing (No deductible)
Not covered: • *Drugs and supplies for cosmetic purposes* • *Non-prenatal vitamins, nutrients and food supplements even if a physician prescribes or administers them, except Vitamin D as described above* • *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*	*All Charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
• *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, page 106).*	*All Charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) dental plan, your FEHB Plan will be 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 and $3,000 for Self and Family enrollment (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c), page 116, 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

Dental benefits	
See *Dental preventive care*, page 94. We have no other dental benefits.	

Section 5(h). Special features

Feature	Description
Flexible benefits option	In certain cases, KPS, at its sole discretion, may choose to authorize coverage for benefits or services that are not otherwise included as covered under this Plan. Such authorization is done on a case-by-case basis if a particular benefit or service is judged to be medically necessary, beneficial and cost effective. However, our decision to authorize services in one instance does not commit us to cover the same or similar services for you in other instances, or to cover the same or similar services in any other instance for any other enrollee. Our decision to authorize services does not constitute a waiver of our right to enforce the provisions, limitations and exclusions of this Plan. 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).
Services for deaf and hearing impaired	KPS utilizes the following Washington state relay numbers: 1-800-833-6388 and 711
Travel benefit/services overseas	**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: KPS Health Plans P.O. Box 339 Bremerton, WA 98337-0039 We will do the translation and currency conversion for you. You may obtain the Overseas Claim Form by calling KPS toll-free at 1-800-552-7114 or from our Web site at www.kpshealthplans.com, Members/Forms and Information. **Note: You are responsible for the cost of all non-urgent/emergent care received outside of Washington state.**

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

Special features	Description
Health education resources	Through **MyKPS** on our Web site at www.kpsfederal.com 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 Web site links
Account management tools	For each HSA account holder, complete payment history and balance information can be found online through www.wellsfargo.com/hsa. For each HRA account holder, complete payment history and balance information can be found online through www.healthsmart.com. This information is also available by calling the Wells Fargo HSA customer service line toll-free at 1-866-884-7374 or the HealthSmart Benefit Solutions customer service line at 1-800-503-9098. You will receive a quarterly statement outlining your account balance and activity for the previous quarter. You will also receive an explanation of benefits (EOB) after every manual (non-debit card) transaction where a check is issued or funds are direct deposited. If you have an HSA, you may also change your investment options online at www.wellsfargo.com/hsa.
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.kpsfederal.com by clicking on Members/Find a Provider. See pages 13 and 18 for further information. Pricing information for prescription drugs and a link to our online pharmacy are available at www.kpsfederal.com by clicking on Pharmacy. Educational materials regarding HSAs are available at www.wellsfargo.com/hsa.
Care support	Patient safety information is available online through **MyKPS** on our Web site at www.kpsfederal.com.

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 related to sex transformations.
- 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, page 139, and Section 10, page 144).
- Applied Behavior Analysis (ABA)

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 at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing 1-800-833-6388 or 711, or at our Web site at www.kpsfederal.com.

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:

KPS Health Plans
Attn: Customer Service
PO Box 339
Bremerton, WA 98337

Prescription drugs

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

- 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:

KPS Claim Reimbursement
P.O. Box 34803
Seattle, WA 98124-1803

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 be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.kpsfederal.com.

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 Customer Service Department by writing to KPS Health Plans, P.O. Box 34593, Seattle, WA 98124-1593 or calling 1-800-552-7114.

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 decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

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: KPS 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) forms. 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.

Step	Description
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied 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 sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-877-828-4514. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 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 the NAIC web site at http://www.NAIC.org.

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

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

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. This is called subrogation.

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

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

You or your representative(s) must obtain a written agreement from us prior to settling any claim if you want us to share, on an equitable basis, any reasonable attorney fees incurred by you in pursuit of any subrogation or reimbursement claim. In the absence of a prior written agreement, we, at our sole discretion, will determine whether or not to reduce our reimbursement amount in order to share, on an equitable basis, any reasonable attorney fees incurred by you. However, such a reduction will only be considered if we have benefited from the services of your attorney. In no event will our reimbursement be reduced by more than 20% to offset attorney fees incurred by you, and we will not pay for other costs incurred by you.

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

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

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

Clinical Trials

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 1-800-MEDICARE (1-800-633-4227), (TTY 1-800-486-2048) 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 141.

- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more parts of Medicare, you can still be covered under the FEHB Program.

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you 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 at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 or 711, or see our Web site at www.kpsfederal.com.

We waive some costs if the Original Medicare Plan is your primary payor.

If you have both Part A and Part B of Medicare, and Original Medicare is your primary payor, we will waive your out-of-pocket costs as follows:

High Option
- Medical and surgical care coinsurance and copayments
- Inpatient hospital coinsurance

Standard Option
- Deductible
- Medical and surgical care coinsurance and copayments
- Inpatient hospital coinsurance

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:

- Non-Medicare member's cost-shares
- Prescription drug copayments per prescription or per refill
- The HDHP deductible and coinsurance
- Your costs (i.e., what Medicare does not pay) for non-urgent/emergent care services received outside our service area (i.e., Washington state)

- **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 1-800-MEDICARE (1-800-633-4227), (TTY 1-800-486-2048) 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), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

	Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.
• **Medicare prescription drug coverage (Part D)**	When we are the primary payor, we process the claim first. If you enroll in 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.

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 25.

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 25.

Experimental or investigational services

A drug, device or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished.

An FDA-approved drug, device or biological product or medical treatment or procedure is experimental or investigational if:

1) Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety; or

2) Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

FDA-approved drugs, devices, or biological products used for their intended purposes and labeled indication and those that have received FDA approval subject to post-marketing approval clinical trials, and devices classified by the FDA as "Category B Non-experimental/investigational Devices" are not considered experimental or investigational.

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

1) It is consistent with the symptom or diagnosis and treatment of the condition;

2) It is the most appropriate supply or level of service that is essential to the member's needs;

3) When applied to an inpatient, it cannot be safely provided to the member as an outpatient;

4) It is appropriate with regard to good medical practice;

5) It is not primarily for the convenience of the member or provider; and

6) It is the most cost-effective of the alternative levels of service or supplies that are adequate and available.

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

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

1) **Plan providers:** Our allowance is the amount agreed upon between the Plan provider and us. Plan providers (except dentists) agree not to bill you for any charges above our allowance.

2) **Non-Plan providers:** We pay 60% of our allowance when you see a non-Plan provider, except in an emergency. You are responsible for all charges above our allowance.

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.

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.
Us/We	Us and We refer to KPS Health Plans.
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 Customer Service Department at 360-478-6796 or toll-free at 1-800-552-7114; for the deaf and hearing-impaired use Washington state's relay line by dialing either 1-800-833-6388 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 25 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 26 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 92 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 91 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 88 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 three 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.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 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 health care expenses (such as copayments, deductibles, insulin, products, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

  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 dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

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

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. **Beginning in 2014, most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

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

Additional Information

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

How do I enroll?

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by 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. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or 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 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557), or visit www.ltfeds.com.

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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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Summary of benefits for the High Option of KPS Health Plans - 2014

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $30	31
Services provided by a hospital:		
• Inpatient	20% of Plan allowance	56
• Outpatient	20% of Plan allowance	57
Emergency benefits:		
• In-area	Emergency Room: $150 copay	61
• In-area	Urgent Care: $30 copay	61
• Out-of-area	Emergency Room: $150 copay	61
• Out-of-area	Urgent Care: $30 copay	61
Mental health and substance abuse treatment:	Regular cost-sharing	63
Prescription drugs:		
• Retail pharmacy	Tier 1: $5 Tier 2: $25 Tier 3: $50	68
• 90-day supply	Tier 1: $10 Tier 2: $50 Tier 3: $100	68
Dental care:		
• Preventive dental care	All charges in excess of the fee schedule allowance.	71
• Basic and Major dental care	$25/person or $50/family deductible, then all charges in excess of the fee schedule allowance, and all charges in excess of the $1,000 annual maximum per member for all services combined (maximum does not apply to children through age 17).	71 - 76
Vision care:		
• Annual eye exam - adult	Nothing	39
• Routine screening eye exams for children through age 17	Nothing (included in Preventive Care)	33

High Option Benefits	You pay	Page
Special features:	See Section 5(h)	79
Point of Service benefits:	See Section 5(i)	80
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/person or $5,000/family per year. Some costs do not count toward this protection	26

Summary of benefits for the Standard Option of KPS Health Plans - 2014

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

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$15 copayment for first four (4) professional office visits. For all subsequent visits 20% coinsurance applies.*	31 - 46
Services provided by a hospital:		
• Inpatient	20% of Plan allowance*	56
• Outpatient	20% of Plan allowance*	57
Emergency benefits:		
• In-area	Emergency Room: 20% of Plan allowance*	61
• In-area	Urgent Care: 20% of Plan allowance*	61
• Out-of-area	Emergency Room: 20% of Plan allowance*	61
• Out-of-area	Urgent Care: 20% of Plan allowance*	61
Mental health and substance abuse treatment:	Regular cost sharing*	63
Prescription drugs:		
• Retail pharmacy	Tier 1: $10 Tier 2: $35 Tier 3: $50	68
• 90-day supply	Tier 1: $20 Tier 2: $70 Tier 3: $100	68
Dental care:		
• Preventive dental care	All charges in excess of the fee schedule allowance.	72
Vision care:		
• Annual eye exam - adult	Nothing	39
• Routine screening eye exams for children through age 17	Nothing (included in Preventive Care)	33
Special features:	See Section 5(h)	79
Point of Service benefits:	See Section 5(i)	80

Standard Option Benefits	You Pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/person or $5,000/family per year. Some costs do not count toward this protection	26

Summary of benefits for the HDHP of KPS Health Plans - 2014

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 2014, for each month you are eligible for a Health Savings Account (HSA), KPS will deposit $62.50 per month for Self Only enrollment or $125 per month for 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 and $3,000 for Self and Family (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, KPS 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 and Family enrollment.

Below, an asterisk (*) means the item is subject to the $1,500 per person ($3,000 per family) calendar year deductible.

HDHP Benefits	You Pay	Page
In-network medical preventive care:	Nothing	93
Preventive dental care:	All charges in excess of the dental fee schedule allowance	94
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*	97
Services provided by a hospital:		
• Inpatient	In-network: 20% of Plan allowance* Out-of-network: 40% of Plan allowance*	116
• Outpatient	In-network: 20% of Plan allowance* Out-of-network: 40% of Plan allowance*	117
Emergency benefits:		
• In-area	20% of Plan allowance*	120
• Out-of-area	20% of Plan allowance*	120
Mental health and substance abuse treatment:	In-network: 20% of Plan allowance* Out-of-network: 40% of Plan allowance*	121
Prescription drugs:		
• Retail pharmacy	Tier 1: $10* Tier 2: $35* Tier 3: $50*	126
• 90-day supply	Tier 1: $20* Tier 2: $70* Tier 3: $100*	126
Dental care - Accidental injury only:	In-network: 20% of Plan allowance* Out-of-network: 40% of Plan allowance*	128
Vision care:		
• Annual eye exam - adult	Nothing (included in Preventive Care)	93

HDHP Benefits	You Pay	Page
• Routine screening eye exams for children through age 17	Nothing (included in Preventive Care)	94
Special features:	See Section 5(h)	129
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $4,000/person or $8,000/family per year (each applies separately for services received from Plan providers and non-Plan providers). Some costs do not count toward this protection.	26

Notes

2014 Rate Information

For 2014 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.