

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

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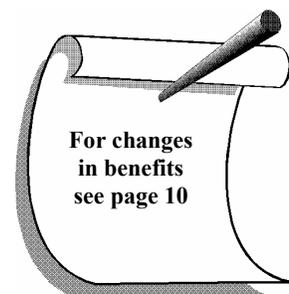
KAISER PERMANENTE®
Kaiser Foundation Health Plan
of the Mid-Atlantic States, Inc.

2006

A Health Maintenance Organization (High and Standard Options)

Serving: Metropolitan Washington, DC Area and
Metropolitan Baltimore, Maryland Area

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



*This Plan has excellent accreditation from the NCQA.
See the 2005 Guide for more information on accreditation.*

Enrollment codes for this Plan:

- E31 High Option Self Only**
- E32 High Option Self and Family**
- E34 Standard Option Self Only**
- E35 Standard Option Self and Family**

Authorized for distribution by the:



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

RI 73-047

Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the Government Accountability Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights as set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

Important Notice from Kaiser Foundation Health Plan of the Mid-Atlantic States About Our Prescription Drug Coverage and Medicare

OPM has determined that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.'s prescription drug coverage is, on average comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in a Medicare Part D Prescription Drug Plan (PDP) and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in a Medicare Part D PDP, you can keep your Kaiser Foundation Health Plan FEHB coverage, but you still need to follow the rules in this brochure for us to cover your care. We will only cover your prescription if it is written by a Plan provider and obtained at a Plan pharmacy or through our Plan mail services delivery program, except in an emergency or urgent care situation. **Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.**

Please be advised

If you lose or drop our coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase at least 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period 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 coverage from these places:

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

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Introduction

This brochure describes the benefits of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., under our contract (CS 1763) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.'s administrative offices is:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20852

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, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehbwcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized 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) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

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

If the provider does not resolve the matter, call us at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area and explain the situation. Our TTY telephone number is 301/879-6380.

If we do not resolve the issue:

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

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

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

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

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

Want more information on patient safety?

- ▶ www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- ▶ 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/index.jsp. 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.
- ▶ www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to use specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you a choice of enrollment in a High Option or a Standard Option.

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

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

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

General features of our High and Standard Options

How we pay providers

We pay the Mid-Atlantic Permanente Medical Group, P.C. (a for-profit Maryland corporation), and contracted community specialists and ancillary providers to provide your medical, surgical, mental health, substance abuse, ophthalmology, optometry, and dental services. We contract with local community hospitals to provide hospitalization services. These Plan providers accept a negotiated payment from us.

Your Rights

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

- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente), is a Health Maintenance Organization.
- This Plan is part of the Kaiser Permanente Medical Care Program, a group of not-for-profit organizations and contracting for-profit medical groups that serve over 8 million members nationwide.
- Kaiser Permanente is a Maryland not-for-profit corporation licensed in the Commonwealth of Virginia, the District of Columbia and the State of Maryland.
- Kaiser Permanente began delivering prepaid healthcare services to Washington, DC residents in December 1972.
- Kaiser Permanente presently serves approximately 500,000 members in the Washington, DC and Baltimore, Maryland metropolitan areas.
- Kaiser Permanente credentials its Plan providers in accordance with national standards.

If you want more information, call us at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380. Write to us at Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Attention: Member Services Department, 2101 E. Jefferson Street, Rockville, Maryland, 20852. You may also contact us by fax at 301/816-6192 or visit our Web site at my.kaiserpermanente.org/federalemployees. Interpreter service is available to assist members who do not speak English. If you need interpreter services, please ask our staff for an interpreter.

Service Area

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

▶ **The District of Columbia**

▶ **The following Virginia counties:**

- Arlington
- Fairfax
- Loudoun
- Prince William

▶ **The following Virginia cities:**

- Alexandria
- Falls Church
- Fairfax
- Manassas
- Manassas Park

▶ **The following Maryland counties:**

- Anne Arundel
- Baltimore
- Carroll
- Harford
- Howard
- Montgomery
- Prince Georges

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

- Calvert – 20639, 20678, 20689, 20714, 20732, 20736, and 20754 zip codes only
- Charles – 20601, 20602, 20603, 20604, 20612, 20616, 20617, 20637, 20640, 20643, 20646, 20658, 20675, 20677, and 20695 zip codes only
- Frederick – 21701, 21702, 21703, 21704, 21705, 21709, 21710, 21714, 21716, 21717, 21718, 21754, 21755, 21758, 21759, 21762, 21769, 21770, 21771, 21774, 21775, 21777, 21790, 21792, and 21793 zip codes only

▶ **Baltimore City, MD**

Ordinarily, you must get your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente service area, you can receive virtually all of the benefits of this Plan at any other Kaiser Permanente facility, including our mail service delivery prescription program. You must pay the charges or copayments imposed by the Kaiser Permanente Plan you are visiting, with the exception of mail service delivery prescriptions which are administered by your home Plan. See Section 5(g), Special Features, for more details. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area and for emergency care obtained from any non-Plan provider. We will not pay for any other health care services.

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

Section 2 How we change for 2006

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

Changes to this Plan

Changes to High Option only

- Your share of the non-Postal premium will increase by 12.2% for Self Only or 15.1% for Self and Family.

Changes to Standard Option only

- Your share of the non-Postal premium will decrease by 16.4% for Self Only or 16.4% for Self and Family.
- We increased the copayment for care you receive in a specialty care department to \$40 per office visit (see page 20).
- We removed the \$100 deductible for prescription drugs.
- We increased the copayment to \$40 per office visit for outpatient physical and occupational therapy and outpatient speech therapy (see page 27).
- We now cover chiropractic services at a \$40 copayment per visit, up to 20 visits per calendar year (see page 35).
- We now cover acupuncture services at a \$40 copayment per visit, up to 20 visits per calendar year (see page 35).
- We increased the copayment to \$40 per office visit for emergency care you receive at a Plan urgent care department (see page 49).
- We increased the copayment to \$40 per office visit for mental health and substance abuse services you receive in a specialty care department (see page 51).
- We added affiliated pharmacies to our pharmacy network. You pay \$25 per prescription or refill for generic drugs; or \$45 per prescription or refill for preferred brand-name drugs; or \$60 per prescription or refill for non-preferred brand-name drugs (see page 54).
- We added a Discounted Dental plan (see page 64).

Changes to both High and Standard Options

- We raised the age limit for dependent children from infancy through age 21 for preventive care in a primary care department. There is no copayment (see page 23).
- We decreased the member coinsurance responsibility to 75% of our allowance for total contact lens package you purchase and service you receive at a Plan facility (see page 29).
- We changed the member payment for asthma-related equipment to 50% of our allowance from a dollar amount (see page 31).
- We no longer cover general health education classes under Plan benefits (see Non-FEHB benefits available to Plan members page 66).
- We have changed the cost of prescription smoking cessation therapy. Now you receive two courses per year (see page 57).

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 (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 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area or write to us at Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Attention: Member Services Department, 2101 E. Jefferson Street, Rockville, Maryland, 20852. Our TTY telephone number is 301/879-6380. You may also request replacement cards through our Web site at my.kaiserpermanente.org/federalemployees.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments or coinsurance, and you will not have to file claims, except for emergency, urgent care services outside our service area, and for covered services while you travel.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We contract with the Mid-Atlantic Permanente Medical Group, P.C., to provide or arrange for primary care services and specialty care services for our members.

Our Provider Directory lists the Plan providers, with locations and phone numbers. Directories are updated annually and are available at the time of enrollment. However, our online Provider Directory is updated biweekly. Our website address is my.kaiserpermanente.org/federalemployees.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members.

If you are visiting another Kaiser Permanente service area, you may receive health care services at those Kaiser Permanente facilities. Under the circumstances specified in this brochure you may receive follow-up or continuing care while you travel anywhere.

Our Provider Directory lists the Plan facilities. Directories are updated annually and are available at the time of enrollment. However, our online Provider Directory is updated biweekly. Our website address is my.kaiserpermanente.org/federalemployees.

What you must do to get covered care

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

To choose a primary care physician you can either select one from our Provider Directory, on our website is my.kaiserpermanente.org/federalemployees or you can call us at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380. We are happy to assist you in selecting a primary care physician.

- **Primary care**

We require you to choose a primary care physician when you enroll. Your primary care physician can be an internal medicine physician, a pediatrician, or a family practice physician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive an approved referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or obtain authorization for all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you an approved referral. You may see Plan gynecologists for routine care, optometrists, or mental health and substance abuse providers without a referral. Members may obtain mental health and substance abuse services without a primary care referral by directly calling our Behavioral Health Access Unit at 866/530-8778 to arrange for services.

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

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

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, is medically necessary, and follows generally accepted medical practice.

We call this review and approval process precertification. Your physician must obtain precertification for:

- Acupuncture
- All inpatient services, except maternity
- Adenoids or tonsil removal
- Ambulance transport (non-emergency)
- Antenatal diagnostic tests outside of the doctor's office
- Bariatric surgery
- Breast surgery not associated with cancer
- Cardiac rehabilitation
- Carpal tunnel surgery
- Chiropractic services
- Clinical trials
- Durable medical equipment
- Genetic testing
- Home health care

Services requiring our prior approval – Continued on next page

**Services requiring our
prior approval**
(continued)

- Hospice care
- Hyperbaric oxygen therapy
- Hysterectomy
- Infertility treatment
- Infusion therapy
- Injectable medications
- Nasal surgery
- Occupational therapy
- Oral surgery and dental services covered under the medical plan
- Organ transplants
- Pain management services
- Physical therapy
- Pulmonary rehabilitation
- Prosthetics
- Radiation therapy
- Reconstructive surgery
- Sclerotherapy for varicose veins
- Sleep studies
- Specialty imaging
- Speech therapy
- Spinal surgery and other invasive spinal procedures not associated with cancer
- Surgical procedures
- Temporomandibular Joint treatment
- Tubes in the ears
- Uterine artery embolization
- Video capsule endoscopy

Requests for these services are made to your primary care physician just like any other referral. Your primary care physician submits the request, with supporting documentation. It takes an average of 2 working days to process the request. You should call your primary care physician's office if you have not been notified of the outcome of the review within 5 working days. If your request is not approved, you have a right to appeal by calling inside the Washington, DC Metropolitan area at 301/468-6000 or toll free at 800/777-7902. Our TTY is 301/879-6380. After business hours, for urgent situations, you may call Appointments/Advice to request an appeal at 703/359-7878, 800/777-7904, TTY is 703/359-7616 or 800/700-4901. If you wish additional services, you must make the request to your primary care physician.

Emergency services do not require precertification. However, you or your family member must notify the Plan within 48 hours, or as soon as reasonably possible.

Section 4 Your costs for covered services

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

Copayments

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

Example: Under the High Option Plan, you pay a copayment of \$10 when your visit takes place in a primary care department, and a copayment of \$20 when your visit takes place in a specialty care department. Under the Standard Option Plan, you pay a copayment of \$30 when your visit takes place in a primary care department, and a copayment of \$40 when your visit takes place in a specialty care department.

Deductible

There is no deductible.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for infertility services, ovulation stimulants, weight management drugs, and oxygen and equipment for home use.

Fees when you fail to make your copayment or coinsurance

If you do not pay your copayment or coinsurance at the time you receive services, we will bill you. You will be required to pay a \$10 charge for each bill sent for unpaid services.

Note: Affiliated physician office and other providers and facilities may bill you an additional charge along with any unpaid copayments, coinsurance or for missed appointments that you fail to cancel.

Your catastrophic protection out-of-pocket maximum

Under the High Option Plan, after your copayments and coinsurance total \$1,750 per person or \$3,500 per family enrollment in any calendar year, you do not have to pay any more for covered services.

Under the Standard Option Plan, after your copayments and coinsurance total \$3,000 per person or \$6,000 per family enrollment in any calendar year, you do not have to pay any more for covered services.

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

- Prescription drugs
- Chiropractic and acupuncture services
- Dental services
- Follow-up continuing care outside the service area
- Infertility services
- Any non-FEHB benefit

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

High and Standard Option Benefits

See page 10 for how our benefits changed this year. Page 87 and page 88 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5 High and Standard Option Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General Exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380. You can also visit our website at my.kaiserpermanente.org/federalemployees.

Kaiser Foundation Health Plan of the Mid Atlantic States (Kaiser Permanente) has been a leader in offering high quality integrated health care to FEHB for more than 25 years. What differentiates Kaiser Permanente from other HMOs and helps us contain your costs is the fact that we view health care not as an industry, but as a cause. Through the Mid-Atlantic Permanente Medical Group (MAPMG) our members receive the highest quality care and attention. Additionally, because MAPMG physicians do not accept patients outside of Kaiser Permanente, our members can rest assured that dedicated physician care will be available at all times. Our seamless delivery system provides convenient, comprehensive care all under one roof. You can come to any one of our 28 medical facilities and see your primary care physician, pediatrician, OB/GYN or specialist, fill prescriptions, have mammograms, complete lab work, plus x-rays and more. Also, our sophisticated health technology gives you the ability 24 hours a day and 7 days a week to book appointments, refill prescriptions, research medical conditions and soon, view your medical information on line.

In 2004, Kaiser Permanente's HMO received "Excellent Accreditation" – the highest level of accreditation possible – from the National Committee for Quality Assurance (NCQA), an independent, non-profit organization that measures the quality of America's health care.

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

High Option

Our High Option provides comprehensive benefits. It includes:

- *No copays for all primary care visits for children under age 5*
- *No copays for preventive care for children under age 22*
- *\$10 per visit to your primary care physician (PCP) for diagnostic services*
- *\$20 per visit to a specialist for diagnostic services*
- *\$100 per admission for inpatient admissions*
- *\$10 per prescription or refill for covered generic drugs obtained at a Plan medical office pharmacy; \$20 per prescription or refill for covered generic drugs obtained at an affiliated network pharmacy*
- *\$20 per prescription or refill for preferred brand name drugs obtained at a Plan medical office pharmacy; \$40 per prescription or refill for preferred brand name drugs obtained at an affiliated network pharmacy*
- *Preventive dental*

Standard Option

We also offer a Standard Option. With the Standard Option your co-payments may be higher than the High Option, but the bi-weekly premium is lower. Specific benefits of our FEHB Standard Option include:

- *No copays for all primary care visits for children under age 5*
- *No copays for preventive care for children under age 22*
- *\$30 per visit to your primary care physician (PCP) for diagnostic services*
- *\$40 per visit to a specialist for diagnostic services*
- *\$250 per day, for inpatient admissions (\$750 maximum per admission)*
- *\$15 per prescription or refill for covered generic drugs obtained at a Plan medical office pharmacy; \$25 per prescription or refill for covered generic drugs obtained at an affiliated network pharmacy*
- *\$25 per prescription or refill for preferred brand name drugs obtained at a Plan medical office pharmacy; \$45 per prescription or refill for preferred brand name drugs obtained at an affiliated network pharmacy*
- *Preventive dental*

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for Medical services and supplies.
- 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 other coverage*, which includes Medicare. Different copayments apply for primary care visits and specialty care visits.

Benefit Description		
Diagnostic and treatment services	You pay High Option	You pay Standard Option
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> ● In physician’s office ● In an urgent care department ● Second surgical opinion 	\$10 per visit in a primary care department (nothing from infancy through age 4) \$20 per visit in specialty care and urgent care departments	\$30 per visit in a primary care department (nothing from infancy through age 4) \$40 per visit in specialty care and urgent care departments
<ul style="list-style-type: none"> ● During a hospital stay ● In a skilled nursing facility Note: See Section 5(c) for facility charges	Nothing	Nothing
At home (in the service area)	Nothing	Nothing
Lab, X-ray and other diagnostic tests		
Tests, such as: <ul style="list-style-type: none"> ● Blood tests ● Urinalysis ● Non-routine Pap smears ● Pathology ● X-rays ● Non-routine mammograms ● Ultrasound ● Electrocardiogram and EEG 	Nothing	Nothing

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

Lab, X-ray and other diagnostic tests (continued)	You pay High Option	You pay Standard Option
Specialty imaging such as: <ul style="list-style-type: none"> ● CAT scans ● MRI ● Pet scans ● Nuclear medicine studies 	\$50 per test	\$100 per test
Preventive care, adult		
Routine screenings, such as: <ul style="list-style-type: none"> ● Total blood cholesterol ● Colorectal cancer screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – Double contrast barium enema – every five years starting at age 50 – Colonoscopy screening – every ten years starting at age 50 ● Bone mass measurement for prevention, diagnosis and treatment of osteoporosis ● Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older ● Chlamydia screenings – women under age 20 who are sexually active and women over age 20 with multiple risk factors ● Human Papillomavirus Screening at testing intervals recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists ● Routine Pap smear ● Travel consultations Note: You should consult with your physician to determine what is appropriate for you.	\$10 per visit in a primary care department (nothing from infancy through age 21) \$20 per visit in a specialty care department	\$30 per visit in a primary care department (nothing from infancy through age 21) \$40 per visit in a specialty care department

Preventive care, adult – continued on next page.

Preventive care, adult <i>(continued)</i>	You pay High Option	You pay Standard Option
<p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> ● Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) ● Influenza vaccines, annually ● Pneumococcal vaccine, age 65 and older and for members at increased risk ● Travel immunizations and vaccines <p>Note: You pay one copayment if you receive your routine screening or immunization on the same day as your office visit.</p>	<p>\$10 per visit in a primary care department (nothing from infancy through age 21)</p> <p>\$20 per visit in a specialty care department</p>	<p>\$30 per visit in a primary care department (nothing from infancy through age 21)</p> <p>\$40 per visit in a specialty care department</p>
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> ● From age 35 to 39, one during this five year period ● From age 40 to 64, one every calendar year ● At age 65 and older, one every two consecutive calendar years 	<p>Nothing</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <p><i>Physical exams required for:</i></p> <ul style="list-style-type: none"> ● <i>Obtaining or continuing employment</i> ● <i>Participating in employee programs</i> ● <i>Insurance or licensing</i> ● <i>Court ordered for parole or probation</i> ● <i>Attending schools</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Preventive care, children	You Pay High Option	You pay Standard Option
<ul style="list-style-type: none"> ● Childhood immunizations recommended by the American Academy of Pediatrics ● Examinations, such as: <ul style="list-style-type: none"> – Eye exams to determine the need for vision correction – Hearing tests to determine the need for hearing correction ● Travel consultations ● Travel immunizations and vaccines <p>Note: You pay one copayment if you receive your routine screening or immunization on the same day as your office visit.</p>	<p>\$10 per visit in a primary care department (nothing from infancy through age 21)</p> <p>\$20 per visit in a specialty care department</p>	<p>\$30 per visit in a primary care department (nothing from infancy through age 21)</p> <p>\$40 per visit in a specialty care department</p>
<p><i>Not covered:</i></p> <p><i>Physical exams required for:</i></p> <ul style="list-style-type: none"> ● <i>Obtaining or continuing employment</i> ● <i>Participating in employee programs</i> ● <i>Insurance or licensing</i> ● <i>Court ordered for parole or probation</i> ● <i>Attending school</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Maternity care		
<p>Complete outpatient maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> ● Prenatal care ● Postnatal care 	<p>\$10 for the first office visit to confirm pregnancy</p> <p>Nothing for outpatient services once pregnancy is confirmed through the post-partum office visit</p>	<p>\$30 for the first office visit to confirm pregnancy</p> <p>Nothing for outpatient services once pregnancy is confirmed through the post-partum office visit</p>

Maternity care – continued on next page.

Maternity care (continued)	You Pay High Option	You pay Standard Option
<ul style="list-style-type: none"> • Inpatient – hospitalization during pregnancy and for delivery • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)). <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> – You do not need to precertify your normal delivery. – You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your inpatient stay will be extended if medically necessary. – We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We cover other care of an infant who requires non-routine treatment only if the infant is covered under a Self and Family enrollment 	<p>\$100 per inpatient admission for hospital charges</p>	<p>\$250 per day up to \$750 maximum per inpatient admission for hospital charges</p>
<p><i>Not covered:</i></p> <p><i>Sonograms that are not medically necessary.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Family planning		
<ul style="list-style-type: none"> • Family planning services, including counseling • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Information on birth control • Genetic counseling <p>Note: We cover surgically implanted time-release contraceptive drugs, injectable contraceptive drugs, intrauterine devices (IUDs), and diaphragms under the prescription drug benefit.</p>	<p>\$10 per visit in a primary care department</p> <p>\$20 per visit in a specialty care department</p>	<p>\$30 per visit in a primary care department</p> <p>\$40 per visit in a specialty care department</p>
<p><i>Not covered:</i></p> <p><i>Reversal of voluntary surgical sterilization</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Infertility services	You Pay High Option	You pay Standard Option
<p>Diagnosis and treatment of involuntary infertility</p> <ul style="list-style-type: none"> ● Artificial insemination: <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) ● Fertility drugs <p>Note: We cover injectable fertility drugs under the prescription drug benefit.</p>	50% of our allowance	50% of our allowance
<p>In vitro fertilization, (limited to three (3) attempts per live birth) if:</p> <ul style="list-style-type: none"> ● your oocytes are fertilized with your spouse’s sperm; and ● you have been unable to become pregnant through a less costly infertility treatment for which coverage is available under the Plan; and ● you and your spouse have a history of infertility of at least 2 years duration; or ● the infertility is associated with endometriosis, exposure in utero to diethylstilbestrol, commonly known as DES, blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy), or abnormal male factors, including oligospermia, contributing to the infertility. 	50% of our allowance; Plan pays up to \$100,000 in a member’s lifetime	50% of our allowance; Plan pays up to \$100,000 in a member’s lifetime
<p><i>Not covered:</i></p> <p><i>These exclusions apply to fertile as well as infertile individuals and couples:</i></p> <ul style="list-style-type: none"> ● <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> ● <i>Donor sperm and donor eggs, including the retrieval of eggs</i> ● <i>Cryopreservation including storage, freezing, and thawing of eggs, sperm, or embryo</i> ● <i>Intracytoplasmic sperm injection (ICSI)</i> ● <i>Surrogacy (host uterus/gestational carrier)</i> ● <i>Preimplantation Genetic Diagnosis (PGI)</i> ● <i>Medical and surgical retrieval of sperm</i> <p><i>Note: Infertility services are not available when either member of the family has been voluntarily surgically sterilized.</i></p>	<i>All charges</i>	<i>All charges</i>

Allergy care	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> • Testing and treatment 	\$10 per visit in a primary care department (nothing from infancy through age 4) \$20 per visit in a specialty care department	\$30 per visit in a primary care department (nothing from infancy through age 4) \$40 per visit in a specialty care department
<ul style="list-style-type: none"> • Allergy injection Note: Allergy serum is covered in full as a part of the office visit copayment.	\$10 per visit	\$30 per visit
<i>Not covered:</i> <ul style="list-style-type: none"> • Provocative food testing • Sublingual allergy desensitization 	<i>All charges</i>	<i>All charges</i>
Treatment therapies		
<ul style="list-style-type: none"> • Respiratory and inhalation therapy • Intravenous/Infusion Therapy Note: We cover growth hormone therapy (GHT) under the prescription drug benefit <ul style="list-style-type: none"> • Qualified medical clinical trials that provide treatment for life-threatening conditions or for preventive, early detection, or treatment studies of cancer for Phases I, II, III and IV • Dialysis – Hemodialysis and peritoneal dialysis • Chemotherapy and radiation therapy Note: We limit high dose chemotherapy in association with autologous bone marrow transplants to those transplants listed under Organ/tissue transplants .	\$10 per visit in a primary care department (nothing from infancy through age 4) \$20 per visit in a specialty care department	\$30 per visit in a primary care department (nothing from infancy through age 4) \$40 per visit in a specialty care department
<i>Not covered:</i> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Cognitive therapy • Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered • Sleep therapy • Thermography and related services 	<i>All charges</i>	<i>All charges</i>

Physical and occupational therapies	You pay High Option	You pay Standard Option
<p>Inpatient and outpatient rehabilitative physical and occupational therapy as defined below:</p> <ul style="list-style-type: none"> Physical therapy by a qualified Plan therapist in consultation with a Plan physician to restore bodily function when you have a total or partial loss of bodily function due to illness or injury Occupational therapy by a Plan therapist in consultation with a Plan physician to assist you in resuming self-care and other activities of daily life when you have a total or partial loss of bodily function due to illness or injury <p>Inpatient Services – up to 2 consecutive months of therapy per condition</p> <ul style="list-style-type: none"> We provide inpatient multidisciplinary rehabilitation in a prescribed, organized program in a plan facility or skilled nursing facility for up to two consecutive months for all covered rehabilitation services and supplies you may receive at different sites for the same condition. <p>Note: The inpatient admission charge is waived if your have been admitted directly from a hospital inpatient stay.</p>	<p>\$100 per inpatient admission</p>	<p>\$250 per day up to \$750 maximum per inpatient admission</p>
<p>Outpatient physical and occupational therapy</p> <ul style="list-style-type: none"> We cover up to 30 office visits or 60 days (whichever is greater) per condition of out-patient physical therapy services We cover up to 90 days per condition of out-patient occupational therapy services <p>Habilitative services for children – from birth to age 19 for the treatment of congenital and genetic birth defects</p> <ul style="list-style-type: none"> We cover services to help a child function age-appropriately within his or her environment and enhance his or her functional ability without an effective cure <p>Cardiac Rehabilitation provided or coordinated by a hospital or other facility which is approved by a physician and includes exercise stress testing, rehabilitative exercises, education and counseling</p> <ul style="list-style-type: none"> We cover services for up to 12 weeks or 36 sessions, whichever first occurs, following coronary surgery or a myocardial infarction 	<p>\$20 per visit in a specialty care department</p>	<p>\$40 per visit in a specialty care department</p>

Physical and occupational therapies – continued on next page.

Physical and occupational therapies (continued)	You pay High Option	You pay Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs • Cognitive rehabilitative programs • Vocational rehabilitative programs • Therapies done primarily for education purposes, except as may otherwise be covered above • Services provided by local, state, and Federal Government agencies including schools 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Speech therapy</p>		
<p>Speech therapy by a Plan therapist in consultation with a Plan physician when medically necessary for habilitative or rehabilitative purposes.</p> <ul style="list-style-type: none"> • Inpatient Services -- up to 2 consecutive months of therapy per condition <p>Note: The admission charge is waived if you have been admitted directly from a hospital inpatient stay</p>	<p>\$100 per inpatient admission</p>	<p>\$250 per day up to a \$750 maximum per inpatient admission</p>
<ul style="list-style-type: none"> • Outpatient Services --up to 90 days per condition per year of outpatient speech therapy <p>Habilitative services for children – from birth to age 19 for the treatment of congenital and genetic birth defects</p> <ul style="list-style-type: none"> • We cover services to help a child function age-appropriately within his or her environment and enhance his or her functional ability without an effective cure 	<p>\$20 per visit in a specialty care department</p>	<p>\$40 per visit in a specialty care department</p>
<p><i>Not covered:</i></p> <p><i>Speech therapy that is not medically necessary such as:</i></p> <ul style="list-style-type: none"> • Therapy for educational placement or other educational purposes • Training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation • Therapy for tongue thrust in the absence of swallowing problems • Voice therapy for occupation or performing arts • Services provided by local, state, and Federal Government agencies including schools 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Hearing services (testing, treatment, and supplies)	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> Hearing tests to determine the need for hearing correction 	\$10 per visit in a primary care department (nothing from infancy through age 21) \$20 per visit in a specialty care department	\$30 per visit in a primary care department (nothing from infancy through age 21) \$40 per visit in a specialty care department
<ul style="list-style-type: none"> Hearing aids for children under age 18, if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist Note: A single hearing aid providing hearing to both ears (binaural hearing aid) is considered two hearing aids for purposes of this benefit.	All charges in excess of \$1,400 for each hearing impaired ear every 36 months	All charges in excess of \$1,400 for each hearing impaired ear every 36 months
<i>Not covered:</i> <ul style="list-style-type: none"> Hearing aids, tests to determine their effectiveness, and examinations for them for all persons 18 and over All other hearing testing 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> Eye exam in the Optometry Department Eye refractions in the Optometry Department Note: Vision services performed outside the Optometry Department will be at the specialty copayment.	\$10 per visit	\$30 per visit
<ul style="list-style-type: none"> Diagnosis and treatment of diseases of the eye Note: These services are performed in a specialist department	\$20 per visit in a specialty care department	\$40 per visit in a specialty care department
<ul style="list-style-type: none"> Eyeglass frames purchased at Plan Optical Shops Eyeglass lenses purchased at Plan Optical Shops 	75% of our allowance	75% of our allowance
Total contact lens package at a Plan facility including <ul style="list-style-type: none"> Initial fitting for contact lenses Initial pair of contact lenses Insertion and removal of contact lens training Three months of follow-up office visits Note: These services are provided only as a total package	75% of our allowance	75% of our allowance

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

Vision services (testing, treatment, and supplies) <i>(continued)</i>	You pay High Option	You pay Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Eye exercises and orthoptics</i> ● <i>Radial keratotomy and other refractive surgery</i> ● <i>Eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism</i> ● <i>Cosmetic contact lenses</i> ● <i>Cost of eyewear not purchased at Plan facilities</i> ● <i>Sunglasses without corrective lenses</i> 	<i>All charges</i>	<i>All charges</i>
Foot care		
<ul style="list-style-type: none"> ● Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease <p>Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per visit in a primary care department \$20 per visit in a specialty care department</p>	<p>\$30 per visit in a primary care department \$40 per visit in a specialty care department</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> ● <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges</i>	<i>All charges</i>
Orthopedic and prosthetic devices		
<ul style="list-style-type: none"> ● Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy 	50% of our allowance	50% of our allowance
<ul style="list-style-type: none"> ● Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy. <p>Notes:</p> <ul style="list-style-type: none"> ● See 5(b) for coverage of the surgery to insert the device. ● These items are covered only when preauthorized in writing by the Plan and when obtained through sources designated by the Plan. 	Nothing	Nothing

Orthopedic and prosthetic devices – continued on next page.

Orthopedic and prosthetic devices (continued)	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> • One hair prosthesis if your hair loss results from chemotherapy or radiation treatment for cancer 	All charges in excess of \$350	All charges in excess of \$350
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Comfort, convenience, or luxury equipment or features</i> • <i>External prosthetic and orthopedic devices, such as braces, foot orthotics, artificial limbs, and lenses following cataract removal</i> • <i>Devices, equipment, supplies and prosthetics related to sexual dysfunction</i> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> 	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)		
<p>We cover prescribed DME for home use.</p> <p>Covered items include:</p> <ul style="list-style-type: none"> • Hospital beds • Wheelchairs • Canes • Walkers • Portable commodes • Crutches • Bilirubin lights and apnea monitors for infants up to age 3 for a period not to exceed 6 months • Continuous Positive Airway Pressure (CPAP) and Bilevel Pressure device (BIPAP) equipment • Oxygen and equipment for home use • Asthma-related equipment (spacers, peak-flow meters, and nebulizers) for adults and children when purchased at a Plan pharmacy 	50% of our allowance	50% of our allowance

Durable Medical Equipment (DME) – continued on next page.

Durable medical equipment (DME) (continued)	You pay High Option	You pay Standard Option
<p>Notes:</p> <ul style="list-style-type: none"> • These items are covered only when preauthorized in writing by the Plan and when obtained through sources designated by the Plan. • Your Plan physician must recertify your medical need for oxygen and oxygen equipment every 30 days. • We decide whether to rent or purchase the equipment, and we select the vendor. We will repair the equipment without charge, unless the repair is due to loss or misuse. You must return the equipment to us or pay us the fair market price of the equipment when it is no longer prescribed. 		
<p>We cover diabetic equipment and supplies when purchased at a Plan pharmacy including:</p> <ul style="list-style-type: none"> • Diabetic equipment • Insulin pumps • Disposable needles and syringes (up to 3 boxes) • Glucose test strips (up to 6 boxes of 50 count) 	20% of our allowance	20% of our allowance
<ul style="list-style-type: none"> • Glucose meter 	\$10 per meter	\$10 per meter
<ul style="list-style-type: none"> • Replacement batteries 	\$5 per package	\$5 per package
<ul style="list-style-type: none"> • Control solutions 	\$8 per package	\$8 per package
<ul style="list-style-type: none"> • Lancets 	\$8 per package	\$8 per package
<p>Note: Lancets, disposable needles and syringes and glucose test strips are available by Plan mail delivery or through Plan pharmacies. Other diabetic supplies in this section are available only at Plan pharmacies.</p> <p>Refer to Section 5(f), Prescription drug benefits, for information about insulin coverage.</p>		

Durable medical equipment (DME) – continued on next page.

Durable medical equipment (DME) (continued)	You pay High Option	You pay Standard Option
<p><i>Not covered:</i></p> <p><i>Note: DME does not include coverage for prosthetic devices such as artificial eyes or legs, or orthotic devices such as braces or therapeutic shoes. Refer to Orthopedic and Prosthetic devices for coverage of internal prosthetic devices and breast prostheses.</i></p> <ul style="list-style-type: none"> ● <i>Oxygen tents</i> ● <i>Motorized wheelchairs</i> ● <i>Comfort, convenience, or luxury equipment or features</i> ● <i>Exercise or hygiene equipment</i> ● <i>Non-medical items such as sauna baths or elevators</i> ● <i>Modifications to your home or car</i> ● <i>Electronic monitors of bodily functions, except apnea monitors and blood glucose monitors</i> ● <i>Disposable supplies except as specifically listed in this section</i> ● <i>Replacement of lost equipment</i> ● <i>Repairs, adjustments, or replacements necessitated by misuse</i> ● <i>More than one piece of durable medical equipment serving essentially the same function, except for replacements other than those necessitated by misuse or loss</i> ● <i>Devices, equipment, supplies, and prosthetics for the treatment of sexual dysfunction disorders</i> ● <i>External and internally implanted hearing aids for all persons age 18 and over</i> ● <i>Experimental or research equipment</i> ● <i>Dental appliances</i> 		

Home health services	You pay High Option	You pay Standard Option
<p>If you are homebound and reside in the service area, we cover home health care ordered by a Plan physician and provided by a registered nurse, licensed practical nurse, licensed vocational nurse, physical therapist, occupational therapist, speech and language pathologist, or home health aide</p> <ul style="list-style-type: none"> • Services include oxygen therapy, intravenous therapy and medications <p>Notes:</p> <ul style="list-style-type: none"> • Your Plan physician will periodically review the home health services for continuing appropriateness and medical need. • The services are covered only if a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home. 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Custodial care</i> • <i>Homemaker services</i> • <i>Services outside the service area</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> • <i>General maintenance care of colostomy, ileostomy, and ureterostomy</i> • <i>Medical supplies or dressings applied by you or a family caregiver</i> • <i>Care that a Plan physician determines may be provided in a Plan facility or skilled nursing facility if we provide or offer to provide that care in one of those facilities</i> • <i>Transportation and delivery service costs of durable medical equipment, medications, drugs, medical supplies, and supplements to the home</i> • <i>Personal care items</i> 	<i>All charges</i>	<i>All charges</i>

Chiropractic	You Pay High Option	You pay Standard Option
<p>Chiropractic services, including spinal manipulation of the neck and back, up to 20 visits per calendar year, for the following services</p> <ul style="list-style-type: none"> • Evaluation and management • Routine chiropractic x-rays provided in the chiropractor's office • Chiropractic adjustments • Adjunctive therapies (e.g., hot and cold packs) • Educational materials <p>Note: You receive these services when your Plan physician, in consultation with the Complementary and Alternative Medicine Department, determines that such care will result in improvement in your condition.</p>	\$20 per visit	\$40 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Structural supports</i> • <i>Nutritional supplements</i> 	<i>All charges</i>	<i>All charges</i>
Alternative treatments		
<p>Acupuncture services up to 20 visits per calendar year, for the following services:</p> <ul style="list-style-type: none"> • Evaluation and management <p>Note: You receive these services when your Plan physician, in consultation with the Complementary and Alternative Medicine Department, determines that such care will result in improvement in your condition.</p>	\$20 per visit	\$40 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Herbal and nutritional supplements</i> 	<i>All charges</i>	<i>All charges</i>

High and Standard Option

Educational classes and programs	You Pay High Option	You pay Standard Option
<ul style="list-style-type: none">Health education for conditions such as diabetes, post-coronary, and nutritional counseling	\$10 per visit in a primary care department \$20 per visit in a specialty care department	\$30 per visit in a primary care department \$40 per visit in a specialty care department
<p><i>Not covered:</i></p> <ul style="list-style-type: none"><i>Educational classes and programs not offered through this Plan</i>	<i>All charges</i>	<i>All charges</i>

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for Surgical and anesthesia services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description		Benefit Description	
Surgical procedures		You pay High Option	You pay Standard Option
A comprehensive range of services, such as: <ul style="list-style-type: none"> ● Operative procedures ● Treatment of fractures, including casting ● Normal pre- and post-operative care by the surgeon ● Pre-surgical testing ● Correction of amblyopia and strabismus ● Endoscopy procedures ● Biopsy procedures ● Removal of tumors and cysts ● Foot surgery including open cutting surgery to remove bunions and spurs ● Correction of congenital anomalies (see Reconstructive surgery) 		\$20 per visit in a specialty care department \$50 per outpatient surgery \$100 per inpatient admission for hospital charges	\$40 per visit in a specialty care department \$100 per outpatient surgery \$250 per day up to \$750 maximum per inpatient admission for hospital charges

Surgical procedures - continued on next page.

Surgical procedures (continued)	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery): You must be at least 18 years of age or older and have a body mass index that is: (i) greater than 40 kilograms per meter squared; or (ii) equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes (see Section 3, <i>Services requiring our prior approval</i>). • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns • Insertion of surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs). Note: We cover the cost of these drugs and devices under the prescription drug benefit (see Section 5(f)) • Insertion of other implanted time-release drugs. Note: We cover the cost of these drugs under the prescription drug benefit (see Section 5(f)) 	<p>\$20 per visit in a specialty care department</p> <p>\$50 per outpatient surgery</p> <p>\$100 per inpatient admission for hospital charges</p>	<p>\$40 per visit in a specialty care department</p> <p>\$100 per outpatient surgery</p> <p>\$250 per day up to \$750 maximum per inpatient admission for hospital charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Reconstructive surgery	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – it 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: <ul style="list-style-type: none"> – surgery to produce a symmetrical of breasts; – treatment of any physical complications, such as lymphedemas; and – breast prostheses and surgical bras and replacements (see Orthopedic and prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$20 per visit in a specialty care department</p> <p>\$50 per outpatient surgery</p> <p>\$100 per inpatient admission for hospital charges</p>	<p>\$40 per visit in a specialty care department</p> <p>\$100 per outpatient surgery</p> <p>\$250 per day up to \$750 maximum per inpatient admission for hospital charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Oral and maxillofacial surgery	You Pay High Option	You pay Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Medical and surgical treatment of TMJ (non-dental) • Other surgical procedures that do not involve the teeth or their supporting structures 	<p>\$20 per visit in a specialty care department</p> <p>\$50 per outpatient surgery</p> <p>\$100 per inpatient admission for hospital charges</p>	<p>\$40 per visit in a specialty care department</p> <p>\$100 per outpatient surgery</p> <p>\$250 per day up to \$750 maximum per inpatient admission for hospital charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) except as covered under the accidental dental benefit.</i> • <i>Shortening of the mandible or maxillae for cosmetic purposes and correction of malocclusion.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Organ/tissue transplants	You pay High Option	You pay Standard Option
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/Lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic donor bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, breast cancer; multiple myeloma and epithelial ovarian cancer • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Unless otherwise authorized by your physician, transplants are covered only at institutions that we designate as “Centers of Excellence” for that specific transplant. If your physician or the transplant facility determines that you do not satisfy the criteria for receiving the transplant, we will pay only for the covered services and supplies you receive before you are notified of that determination.</p>	<p>\$20 per visit in a specialty care department</p> <p>\$50 per outpatient surgery</p> <p>\$100 per inpatient admission for hospital charges</p>	<p>\$40 per visit in a specialty care department</p> <p>\$100 per outpatient surgery</p> <p>\$250 per day up to \$750 maximum per inpatient admission for hospital charges</p>

Organ/tissue transplants – continued on next page.

Organ/tissue transplants <i>(continued)</i>	You pay High Option	You pay Standard Option
<p>Limited Benefits: Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute (NCI) – or National Institutes of Health (NIH)-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses for a living donor when those expenses are directly related to your covered transplant.</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except screening blood tests and advanced testing performed for the actual donor</i> • <i>Implants of non-human or artificial organs</i> • <i>Transplants not listed as covered except when approved by the Clinical Management Committee of the National Transplant Network</i> 	<i>All charges</i>	<i>All charges</i>
Anesthesia		
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office 	Nothing	Nothing

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible for Services provided by a hospital or other facility, and ambulance charges.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS** (except for Maternity stays). Please refer to Section 3 to be sure which services require precertification.

Benefit Description		Benefit Description	
Inpatient hospital	You pay High Option	You pay Standard Option	
Room and board, such as: <ul style="list-style-type: none"> ● Ward, semiprivate, or intensive care accommodations ● General nursing care ● Medically necessary special duty nursing ● 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.	\$100 per inpatient admission	\$250 per day up to \$750 maximum per inpatient admission	

Inpatient hospital – continued on next page.

Inpatient hospital <i>(continued)</i>	You pay High Option	You pay Standard Option
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Procurement and storage for approved medically necessary cord blood for a designated recipient • Administration of blood and blood products • Blood or blood plasma, if donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take home items • Hospitalization for inpatient foot treatment <p>Note: You may receive covered medical hospital services for certain dental procedures if a Plan physician determines that you need to be hospitalized. Section 5(h), Dental benefits, includes more information on the requirements.</p>	<p>\$100 per inpatient admission</p>	<p>\$250 per day up to \$750 maximum per inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> • <i>Whole blood and packed red blood cells not replaced by the member</i> • <i>Procurement and storage of cord blood for possible future need or for yet to be determined Member recipient</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Outpatient hospital or ambulatory surgical center	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> ● Operating, recovery, and other treatment rooms ● Prescribed drugs and medicines ● Diagnostic laboratory tests, X-rays, and pathology services ● Procurement and storage of cord blood for approved medically necessary procedures requiring cord blood for a designated recipient ● Administration of blood and blood products ● 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 	\$50 per outpatient surgery	\$100 per outpatient surgery
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Whole blood and packed red blood cells not replaced by the member</i> ● <i>Procurement and storage of cord blood for possible future need or for yet to be determined member recipient</i> 	<i>All charges</i>	<i>All charges</i>
Skilled nursing care benefits		
<p>Up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate. We cover the following:</p> <ul style="list-style-type: none"> ● Physician and nursing services ● Room and board ● Medical social services ● Administration of blood, blood products, and derivatives ● Durable medical equipment ordinarily furnished by a skilled nursing facility, including oxygen-dispensing equipment and oxygen ● Respiratory therapy ● Biological supplies ● Medical supplies <p>Note: We waive the additional admission charge if you are admitted to an extended care or skilled nursing facility directly from a hospital inpatient stay.</p>	\$100 per inpatient admission	\$250 per day up to \$750 maximum per inpatient admission

Skilled nursing care benefits – continued on next page.

Skilled nursing care benefits <i>(continued)</i>	You pay High Option	You pay Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Care in an intermediate care facility 	<i>All charges</i>	<i>All charges</i>
Hospice care		
<p>Supportive and palliative care for a terminally ill member</p> <ul style="list-style-type: none"> • You must reside in the service area • Services are provided in your home, if a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home, or • Services are provided in a Plan approved hospice facility <p>Services include inpatient care, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less.</p> <p>Note: Hospice is a program for caring for the terminally ill that emphasizes supportive services, such as home care and pain control, rather than curative care of the terminal illness. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, physician services, and short-term inpatient care for pain control and acute and chronic symptom management. We also provide counseling and bereavement services for the individual and family members, and therapy for purposes of symptom control to enable the person to continue life with as little disruption as possible. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.</p>	Nothing	Nothing

Hospice care – continued on next page.

Hospice care <i>(continued)</i>	You pay High Option	You pay Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Private duty nursing (independent nursing)</i> • <i>Homemaker services</i> 	<i>All charges</i>	<i>All charges</i>
<p>Ambulance</p> <ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate <p>Note: We cover each encounter for ambulance services only if ambulance transport is medically necessary and has been ordered by a Plan Provider. Coverage is also provided for medically necessary transportation or services rendered as the result of a 911 call, whether or not transport is required.</p>	Nothing	\$100 per encounter

Section 5(d) Emergency services/accidents

Here are some 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.
- We have no calendar year deductible for Emergency services/accidents.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

In a life threatening emergency-call the local emergency system (e.g., the local 911 telephone system). When the operator answers, stay on the phone and answer all questions. If you are not sure whether you are experiencing a medical emergency, please contact our Emergency Line at 800/677-1112.

Emergencies within our service area:

Emergency care is provided at Plan Hospitals 24 hours a day, seven days a week.

If you think you have a medical emergency condition and you cannot safely go to a Plan Hospital, call 911 or go to the nearest hospital. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify us within 48 hours, or as soon as is reasonably possible, by calling 703/359-7878 inside the Washington, DC metropolitan area or toll free 800/777-7904. Our TTY is 703/359-7616 or 800/700-4901.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in non-Plan facilities and Plan physicians believe care can be better provided in a Plan Hospital, we will transfer you when medically feasible, with any ambulance charges covered in full.

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

Emergencies outside our service area:

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

If you need to be hospitalized, the Plan must be notified within 48 hours or as soon as is reasonably possible. If a Plan physician believes care can be better provided in a Plan Hospital, we will transfer you when medically feasible, with any ambulance charges covered in full.

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local telephone book under Kaiser Permanente. These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling the Membership Services department at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380.

Benefit Description		
Emergency within our service area	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> Emergency care at a Plan urgent care department 	\$20 per visit	\$40 per visit
<ul style="list-style-type: none"> Emergency care in a hospital emergency room <p>Notes:</p> <ul style="list-style-type: none"> Your hospital emergency room visit copayment is waived if you are admitted to a Plan Hospital as an inpatient. Your hospital inpatient copayment will apply (See Section 5(c)). Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit copayment will not be waived. 	\$50 per visit	\$100 per visit
<p><i>Not covered:</i></p> <p><i>Elective care or non-emergency care</i></p>	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area		
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$20 per visit	\$40 per visit
<ul style="list-style-type: none"> Emergency care in a Kaiser Foundation hospital in another Kaiser Foundation Health Plan service area Emergency care in a non-Plan hospital emergency room <p>Notes: We waive your hospital emergency room visit copayment if you are admitted to a Plan Hospital as an inpatient. Your hospital inpatient copayment will apply (See Section 5(c)).</p> <p>Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit copayment will not be waived.</p> <p>See the Travel Benefit for coverage of continuing or follow-up care.</p>	\$50 per visit	\$100 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>	<i>All charges</i>

High and Standard Option

Ambulance	You Pay High Option	You pay Standard Option
<ul style="list-style-type: none">Professional ambulance service, including air ambulance, when approved by the Plan. <p>Note:</p> <ul style="list-style-type: none">We cover each encounter for ambulance services only if ambulance transport is medically necessary and has been ordered by a Plan Provider. Coverage is also provided for medically necessary transportation or services rendered as the result of a 911 call, whether or not transport is required.See Section 5(c) for non-emergency ambulance service.	Nothing	\$100 per encounter

Section 5(e) Mental health and substance abuse benefits

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

Here are some 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 clinically appropriate to treat your condition.
- We have no calendar year deductible for Mental health and substance abuse benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Plan physicians must provide or arrange your care.

Benefit Description			
Mental health and substance abuse benefits	You pay High Option	You pay Standard Option	
<p>We cover all diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Notes:</p> <ul style="list-style-type: none"> ● We cover the services only when we determine that the care is clinically appropriate to treat your condition, and only when you receive the care as part of a treatment plan developed by a Plan provider. ● 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 in favor of another. 	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	
<p>Diagnosis and treatment of psychiatric conditions, mental illness, or disorders of children, adolescents, and adults. Outpatient services include:</p> <ul style="list-style-type: none"> ● Diagnostic evaluation ● Crisis intervention and stabilization for acute episodes ● Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment ● Outpatient psychiatric treatment (including individual and group therapy visits) ● Medication evaluation and management <ul style="list-style-type: none"> — Including, but not limited to, methadone maintenance treatment 	<p>\$10 per visit in a primary care department</p> <p>\$20 per visit in a specialty care department</p>	<p>\$30 per visit in a primary care department</p> <p>\$40 per visit in a specialty care department</p>	

Mental health and substance abuse benefits – continued on next page.

Mental health and substance abuse benefits <i>(continued)</i>	You pay High Option	You pay Standard Option
<p>Diagnosis and treatment of alcoholism and drug abuse. Services include:</p> <ul style="list-style-type: none"> ● Detoxification (medical management of withdrawal from the substance) ● Treatment and counseling (including individual and group therapy visits) as part of intensive outpatient programs ● Intensive day treatment ● Methadone treatment 	<p>\$10 per visit in a primary care department</p> <p>\$20 per visit in a specialty care department</p>	<p>\$30 per visit in a primary care department</p> <p>\$40 per visit in a specialty care department</p>
<p>Notes:</p> <ul style="list-style-type: none"> ● You may see a Plan provider for outpatient treatment without a referral from your primary care physician. <p>Your Plan provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you.</p>		
<ul style="list-style-type: none"> ● Inpatient psychiatric care ● Inpatient detoxification ● Acute inpatient substance abuse rehabilitation <p>Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan physician. Inpatient services will only be part of a treatment plan when services cannot be provided safely on an outpatient basis or in a less intensive setting than an acute care hospital.</p>	<p>\$100 per inpatient admission for hospital charges</p>	<p>\$250 per day up to \$750 maximum per inpatient admission for hospital charges</p>
<ul style="list-style-type: none"> ● Hospital alternative services: partial hospitalization, intensive outpatient psychiatric treatment programs and residential crisis services. 	<p>\$20 per visit; or \$100 per inpatient admission if your treatment is more than 24 continuous hours</p>	<p>\$40 per visit; or \$250 per day up to \$750 maximum per inpatient admission if your treatment is more than 24 continuous hours</p>

Mental health and substance abuse benefits – continued on next page.

Mental health and substance abuse benefits (continued)	You pay High Option	You pay Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Care that is not clinically appropriate for the treatment of your condition</i> ● <i>Services we have not approved</i> ● <i>Intelligence, IQ, aptitude ability, learning disabilities, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition</i> ● <i>Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate</i> ● <i>Services that are custodial in nature</i> ● <i>Marital, family, or educational services</i> ● <i>Services rendered or billed by a school or a member of its staff</i> ● <i>Services provided under a federal, state, or local government program</i> ● <i>Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on page 56.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A plan physician, authorized provider, or licensed contracted dentist must write the prescription.
- **Where you can obtain them.** If you are enrolled in the High Option or the Standard Option plan, you must fill the prescription at a Plan pharmacy, an affiliated network pharmacy, or by the Plan mail service delivery program. We will pay for prescriptions written by a non-Plan physician and filled at a non-Plan pharmacy only when the prescription was given during a hospital emergency room visit or an urgent care visit outside the service area.
- **We use a preferred drug list.** Our preferred drug list (formulary) is a list of prescribed drugs (generic and preferred brand name) and accessories that have been approved by our Pharmacy and Therapeutics Committee for our Members. The preferred drug list contains both generic and brand name drugs. Brand name drugs that are not on our preferred drug list, known as non-preferred drugs, are available under the benefit at a higher copayment.

Our Pharmacy and Therapeutics Committee, which is comprised of Plan physicians, Plan providers, and our pharmacists, selects prescription drugs and accessories for the preferred drug list (formulary) based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. In addition, the Committee sets dispensing limitations in accord with therapeutic guidelines based on the medical literature and research. The Pharmacy and Therapeutics Committee meets periodically to consider adding and removing prescribed drugs and accessories on the preferred drug list (formulary).

If you would like information about whether a particular drug or accessory is included in our preferred drug list (formulary), please visit us on line at my.kaiserpermanente.org/federalempleeoes, or call our Member Services Department at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380.

- **These are the dispensing limitations.** We provide up to a 30-day supply for one copayment based upon (a) the prescribed quantity, (b) the standard manufacturer's package size, (c) specified dispensing limits, (d) the type of drug, and (e) the place of purchase. We provide up to a 90-day supply of maintenance drugs for two mail service delivery copayments when ordered through our Plan's mail service delivery program. A maintenance drug is a drug that your physician anticipates you will require for 6 months or more to treat a chronic condition. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call our Member Services Department at 301/468-6000.

Prescription drugs – continued on next page

Prescription drugs (continued)

Generic vs. brand name drugs

Why use generic drugs? Unless otherwise specified by your Plan physician or dentist, generic drugs may be used to fill prescriptions. Kaiser Permanente providers have successfully included the use of generic drugs as part of patient care without compromising quality. Generic drugs offer a safe and economic way to meet your medication needs. They are less expensive than brand name drugs - therefore you may reduce your out-of-pocket costs by choosing to use a generic drug. Generic drugs must contain the same active ingredients and be equivalent in strength and dosage to the original brand name product. The U.S. Food and Drug Administration and also Kaiser Permanente set criteria for the use of generic drugs to ensure that they meet the same standards of purity, strength and quality as brand-name drugs. They are expected to have the same therapeutic effect as the brand name product. Not all drugs have a generic equivalent. If a generic drug is unavailable, the appropriate brand copayment will apply.

Brand name drugs will be covered only when:

- (1) prescribed by a plan physician, authorized provider, or by a licensed, contracted dentist; and
- (2) (a) there is no equivalent generic drug, or (b) an equivalent generic drug
 - has been ineffective in treating the disease or condition of the Member; or
 - has caused or is likely to cause an adverse reaction or other harm to the member.

If you request a brand name drug for any reason other than those listed above, you will be responsible for the full charge for that drug.

Preferred brand name vs. non-preferred brand name drugs

Plan Pharmacies will use drugs from the preferred drug list unless prohibited by the prescribing provider.

Non-preferred brand name drugs will be covered only when:

- (1) prescribed by a plan physician, authorized provider, or by a licensed, contracted dentist; and
- (2) (a) there is no equivalent generic drug, or (b) an equivalent generic drug
 - has been ineffective in treating the disease or condition of the Member; or
 - has caused or is likely to cause an adverse reaction or other harm to the member.

If you request a brand name drug for any reason other than those listed above, you will be responsible for the full charge for that drug.

When you have to file a claim. When you receive drugs from a Plan pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy. To file a claim, you should contact the Plan's Member Services Department at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area and obtain a claim form. Our TTY is 301/879-6380. A claim for reimbursement must be submitted to the Plan within 12 months after you purchased the prescribed drugs. Members must pay full price for the drug and then submit a claim for reimbursement subject to the terms and conditions of the Plan.

Prescription drug benefits begin on next page.

Benefit Description		
Covered medications and supplies	You pay High Option	You pay Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy, an affiliated network pharmacy, or through the Plan’s mail service delivery program:</p> <ul style="list-style-type: none"> ● Drugs for which a prescription is required by law ● Insulin (up to six (6) vials) ● Disposable needles and syringes for the administration of covered medications ● Contraceptive drugs ● Intrauterine devices (IUDs) and diaphragms ● Implanted time-release contraceptive drugs 	<p>30-day supply at a Plan medical center pharmacy: \$10 per prescription or refill for generic drugs; or \$20 per prescription or refill for preferred brand-name drugs; or \$35 per prescription or refill for non-preferred brand-name drugs</p>	<p>30-day supply at a Plan medical center pharmacy: \$15 per prescription or refill for generic drugs; or \$25 per prescription or refill for preferred brand-name drugs; or \$40 per prescription or refill for non-preferred brand-name drugs</p>

Covered medications and supplies – continued on next page.

Covered medications and suppliers (continued)	You Pay High Option	You pay Standard Option
<ul style="list-style-type: none"> ● Other implanted time-release drugs ● Injectable contraceptive drugs ● Self-injectable drugs, other than ovulation stimulants ● Self-administered chemotherapeutic drugs and oral chemotherapeutic agents ● Self-administered post-surgical immunosuppressant outpatient drugs required as a result of a covered transplant ● Growth hormone therapy (GHT) – for treatment of children with growth hormone deficiency ● Smoking cessation <ul style="list-style-type: none"> A. Except for a drug that may be obtained over-the-counter without a prescription, benefits will be provided for any drug that is approved by the United States Food and Drug Administration as an aid for the cessation of the use of tobacco products; and B. Benefits will also be provided for two (2) ninety (90) day courses of Nicotine Replacement Therapy per calendar year. <p><i>Nicotine Replacement Therapy</i> means a product that:</p> <ol style="list-style-type: none"> 1. is used to deliver nicotine to an individual attempting to cease the use of tobacco products; and 2. is obtained under a prescription written by an authorized prescriber. <p>Nicotine Replacement Therapy does not include any over-the-counter products that may be obtained without a prescription.</p> <p>Notes:</p> <ul style="list-style-type: none"> ● Compounded preparations must contain at least one ingredient requiring a prescription. ● Nicotine Replacement Therapy does not include any over-the-counter products that may be obtained without a prescription. 	<p>30-day supply at an affiliated network pharmacy: \$20 per prescription or refill for generic drugs; or \$40 per prescription or refill for preferred brand-name drugs; or \$55 per prescription or refill for non-preferred brand-name drugs</p> <p>30-day supply through our mail service delivery program: \$8 per prescription or refill for generic drugs; or \$18 per prescription or refill for preferred brand-name drugs; or \$33 per prescription or refill for non-preferred brand-name drugs</p> <p>90-day supply of maintenance drugs through our mail service delivery program: \$16 per prescription or refill for generic drugs; or \$36 per prescription or refill for preferred brand-name drugs; or \$66 per prescription or refill for non-preferred brand-name drugs</p>	<p>30-day supply at an affiliated network pharmacy: \$25 per prescription or refill for generic drugs; or \$45 per prescription or refill for preferred brand-name drugs; or \$60 per prescription or refill for non-preferred brand-name drugs</p> <p>30-day supply through our mail service delivery program: \$13 per prescription or refill for generic drugs; or \$23 per prescription or refill for preferred brand-name drugs; or \$38 per prescription or refill for non-preferred brand-name drugs</p> <p>90-day supply of maintenance drugs through our mail service delivery program: \$26 per prescription or refill for generic drugs; or \$46 per prescription or refill for preferred brand-name drugs; or \$76 per prescription or refill for non-preferred brand-name drugs</p>
<ul style="list-style-type: none"> ● Clinically administered post-surgical immunosuppressant outpatient drugs required as a result of a covered transplant ● Intravenous fluids and medications for home use ● Clinically administered chemotherapy drugs 	<p>Nothing</p>	<p>Nothing</p>

Covered medications and supplies – continued on next page.

Covered medications and supplies <i>(continued)</i>	You pay High Option	You pay Standard Option
<ul style="list-style-type: none"> • Amino acid modified products used to treat congenital errors of amino acid metabolism (PKU) 	25% of our allowance	25% of our allowance
<p>Note: See Section 5(a) – Medical services and supplies provided by physicians and other health care professionals for coverage of diabetic equipment and supplies including glucose test strips, disposable needles and syringes, lancets, and control solutions.</p>		
<ul style="list-style-type: none"> • Weight management drugs for treatment of morbid obesity • Drugs for covered infertility treatments • Drugs for sexual dysfunction <p>Note: Drugs to treat sexual dysfunction have dispensing limitations. Please contact the Plan for details.</p>	50% of our allowance	50% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs obtained at either a non-Plan pharmacy or non-affiliated network pharmacy except for emergencies inside and outside the service area</i> • <i>Drugs or supplies for cosmetic purposes</i> • <i>Vitamins and nutritional supplements that can be purchased without a prescription</i> • <i>Nonprescription drugs</i> • <i>Prescription drugs for which there is a nonprescription equivalent available</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs related to non-covered infertility services</i> • <i>Drugs for non-covered services</i> • <i>Dental prescriptions other than those prescribed for pain relief or antibiotics</i> • <i>Replacement prescriptions necessitated by theft, loss, or damage</i> • <i>Drugs to shorten the duration of the common cold</i> • <i>Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) different from Plan’s standard packaging</i> 	<i>All charges</i>	<i>All charges</i>

Section 5(g) Special features

Feature	Description
<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other treatments as a less costly alternative benefit. • Alternative treatments are subject to our ongoing review. • By approving an alternative treatment, we cannot guarantee you will get it in the future. • The decision to offer an alternative treatment is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative treatments is not subject to OPM review under the disputed claims process.
<p>24 hour nurse line</p>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 703/359-7878 inside the Washington, DC metropolitan area or 800/777-7904 outside the Washington, DC metropolitan area or call our TTY at 703/359-7616 or 800/700-4901 and talk with a registered nurse who can help assess medical symptoms and provide advice over the phone, when medically appropriate.</p>
<p>Services for deaf and hearing impaired</p>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 703/359-7616 inside the Washington, DC metropolitan area or 800/700-4901 outside the Washington, DC metropolitan area and talk with a registered nurse who will discuss treatment options and answer your health questions.</p> <p>During regular business hours Monday through Friday, you may contact our Member Services Department with any questions concerning the Plan and how to obtain services by calling 301/879-6380.</p>
<p>Centers of Excellence</p>	<p>The Centers of Excellence program began in Fall 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted “Centers of Excellence” for certain specialized medical procedures.</p> <p>We have developed a national contract network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.</p>

Travel benefit

Kaiser Permanente's travel benefits for Federal employees provide you with outpatient follow-up or continuing medical care when you are temporarily (for example, on a temporary work assignment or attending school) outside your home service area by more than 100 miles or outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency and urgent care benefits and include:

- Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast.
- Outpatient continuing care for covered services for conditions diagnosed and treated within the previous 90 days by a Kaiser Permanente health care provider or affiliated Plan provider. Services include dialysis and prescription drug monitoring.
- You pay \$25 for each follow-up or continuing care office visit. This amount will be deducted from the payment we make to you.
- Your benefit is limited to \$1,200 each calendar year.
- For more information about this benefit you should contact the Plan's Member Services Department at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY is 301/879-6380.
- File claims as shown in Section 7.

The following are a few examples of services not included in your travel benefits coverage:

- Non-emergency hospitalization
- Infertility treatments
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area
- Transplants
- DME
- Prescription drugs
- Home health services

Services from other Kaiser Permanente plans

When you are visiting in the service area of another Kaiser Permanente plan, you are entitled to receive virtually all the services described in this brochure (including our mail service delivery prescription program) at any Kaiser Permanente medical office or medical center. You must pay the charges or copayments imposed by the Kaiser Permanente plan you are visiting, with the exception of mail service delivery prescriptions which are administered by your home Plan. You will have to pay the charges imposed by the Plan you are visiting. If the Plan you are visiting has a services that is different from the services of this Plan, you are not entitled to receive that service.

Some services covered by this Plan, such as artificial reproductive services and the services of specialized rehabilitation facilities, will not be available in other Kaiser Permanente service areas. If a service is limited to a specific number of visits or days, you are entitled to receive only the number of visits or days covered by the Plan in which you are enrolled.

If you are seeking routine, non-emergent, or non-urgent services, you should call the Kaiser Permanente Membership Services Department in that service area and request an appointment. You may obtain routine follow-up or continuing care from these plans, even when you have obtained the original services in the service area of this Plan. If you require emergency services as the result of unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care.

At the time you register for services, you will be asked to pay the charges required by the local Plan.

If you plan to travel to an area with another Kaiser Permanente plan, and wish to obtain more information about the services available to you from the Kaiser Permanente plan, please call Membership Services at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY is 301/879-6380.

Section 5(h) Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible for Dental benefits.
- The Discounted Fee – Dental Benefits apply to both the High Option Plan and Standard Option Plan members.
- We cover hospitalization for dental procedures only under the conditions described in this subsection. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description		
Accidental injury benefit	You pay High Option	You pay Standard Option
<p>We cover restorative services and supplies necessary to promptly repair (but not replace) your sound natural teeth that you have injured as the result of an external force (not chewing). A sound natural tooth is one that has not been weakened by existing dental pathology such as, decay or periodontal disease, or previously restored with a crown, inlay, onlay or porcelain restoration, or treatment by endodontics.</p> <p>Note: You must start to receive services within 60 days of your accident and complete them within 12 months of your accident. You are only covered for the most cost effective procedure that will produce a satisfactory result.</p>	<p>\$10 per visit in a primary care department</p> <p>\$20 per visit in a specialty care department</p> <p>All charges in excess of \$2,000 per member per accident</p>	<p>\$30 per visit in a primary care department</p> <p>\$40 per visit in a specialty care department</p> <p>All charges in excess of \$2,000 per member per accident</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ● <i>Injuries to non-sound natural teeth</i> ● <i>Services required after the 12-month period</i> ● <i>Services that are needed, but did not start until later than 60 days after the accident</i> ● <i>Services for teeth that have been so severely damaged that restoration is impossible, in the opinion of the Plan dental provider</i> ● <i>Services for teeth that have been knocked-out</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Other dental benefits	You pay High Option	You pay Standard Option
<p>We cover general anesthesia and associated hospital or ambulatory surgery facility charges in conjunction with dental care provided by a fully accredited specialist in pediatric dentistry, fully accredited specialist in oral and maxillofacial surgery, or a dentist for whom hospital privileges has been granted, for the following members.</p> <ul style="list-style-type: none"> • Children, 7 years of age or younger, who are developmentally disabled, for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition, for whom a superior result can be expected from dental care provided under general anesthesia • Children, 17 years of age or younger, and extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred; and whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity • Adults, age 17 and older, whose medical condition requires that dental service be performed in a hospital or ambulatory surgical center for their safety (e.g., heart disease and hemophilia) 	<p>\$10 per visit in a primary care department \$20 per visit in a specialty care department \$50 per outpatient surgery \$100 per inpatient admission</p>	<p>\$30 per visit in a primary care department \$40 per visit in a specialty care department \$100 per outpatient surgery \$250 per day up to \$750 maximum per inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>The dentist's or specialist's professional services</i> • <i>Dental care for temporal mandibular joint (TMJ) disorders</i> • <i>Lab fees associated with cysts that are considered dental according to our medical guidelines</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Discounted Fee - Dental Benefits

For High Option and Standard Option plan members, Kaiser Permanente has entered into an Agreement with Dental Benefit Providers, Inc. (“DBP”), under which DBP will provide or arrange for the provision of covered dental services to you through Participating Dental Providers.

- Your Kaiser Permanente Dental Plan booklet includes a directory of Participating Dental Providers and a schedule of discounted fees for covered dental services. You can obtain a Dental Plan booklet by calling our Member Services Department at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY is 301/879-6380.
- All dental procedures listed in the schedule of discounted fees are covered dental services. When you receive any of the listed procedures from a Participating Dental Provider, you will pay the fee listed next to the procedure description for that service. The Participating Dental Provider has agreed to accept that fee as payment in full for that procedure. Neither Kaiser Permanente nor DBP are liable for payment of these fees or for any fees incurred as the result of receipt of non-covered dental services.
- You will pay a fixed rate of \$30 for each preventive care office visit, which includes oral evaluation, cleaning, and certain x-ray procedures. You will pay discounted fees for the other covered dental services as listed in your Dental Plan booklet.
- Your Dental Plan booklet also includes a directory of Participating Dental Providers. DBP offers a large network of general dentists in our service area. You may select a Participating Dental Provider, who is a “general dentist”, from whom you and your eligible family members will receive covered dental services. For specialty care, your general dentist must refer you to a specialist who is a Participating Dental Provider. Your discounted fees are higher for care received by a Participating Dental Provider who is a specialist. Please refer to the discounted schedule of fees in your Dental Plan booklet for specialists’ fees.
- When a dental emergency occurs outside our service area, Kaiser Permanente will reimburse you for the reasonable charges, less any discounted fee, upon proof of payment, not to exceed \$50 per incident. We cover emergency dental treatment required to alleviate pain, bleeding, or swelling. If post-emergency care is required, you must receive all post-emergency care from your Participating Dental Provider.

The list below is a sample of dental services and fees. For a complete list of dental services, fees, limitations, and exclusions refer to your Kaiser Permanente Dental Plan booklet. FC = Fixed copayment. NB = No benefit

Dental benefits		
Service		
PROCEDURE NAME	You Pay – High and Standard Options TO DENTIST	You Pay – High and Standard Options TO SPECIALIST

Diagnostic Services

Routine and Comprehensive Clinical Oral Evaluation	FC \$30	NB
Radiographs/Diagnostic Imaging	FC \$30	NB

Preventive Services

Prophylaxis Adult (every 6 months)	FC \$30	NB
Topical Fluoride Including Prophy – Under age 16	FC \$30	NB

High and Standard Option

Space Maintainers	\$226	NB
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Restorative Services

Fillings (amalgam, resin-based composite)	\$30	NB
Crown (resin, porcelain, base metal, noble metal)	\$531	NB

Endodontic Services

Root Canal Therapy	\$253	\$319
Apexification/Recalcification Procedures	\$313	\$614

Periodontic Services

Gingivectomy/Gingivoplasty	\$59	\$90
Periodontal Scaling/Root Planing	\$36	\$70

Prosthetics-Removable

Complete and Partial Dentures	\$525	NB
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Prosthetics-Fixed

Bridges, Crown	\$39	NB
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Oral Surgery

Extraction	\$47	\$53
Excision of Benign Lesion	\$111	\$168

Orthodontics

Comprehensive Ortho Treatment-Adolescent or Adult Dentition	NB	\$2,375 (Adolescent) \$2,675 (Adult)
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Additional Procedures

Palliative-Emergency Treatment of Dental Pain, Minor Procedure	\$28	NB
Deep Sedation/General Anesthesia-1 st 30 Minutes	\$74	\$185

Fees shown are sample fees. The fee charged will depend on the actual services rendered.

Limitations and exclusions to dental services: There are limitations and exclusions to your dental coverage. For complete details regarding your dental benefits, exclusions and limitations, please refer to your Kaiser Permanente Dental Plan booklet.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Medicare Prepaid Plan Enrollment

We offer Medicare recipients the opportunity to enroll in our Plan through Medicare. Annuitants and former spouses with FEHB coverage and Medicare Parts A and B or Part B only may elect to either drop their FEHB coverage and enroll in a Medicare prepaid plan or remain enrolled in the FEHB Program and simultaneously enroll in the Medicare prepaid plan when one is available in their area. If you choose to disenroll from the FEHB Program you may then later re-enroll in the FEHB Program. Before you drop your FEHB coverage and apply for coverage in the Medicare prepaid plan, please contact us at 301/816-5690 or 301/816-6143.

Expanded Dental Benefits

We are pleased to offer you an additional choice of dental coverage to supplement what is currently available to you through the FEHB program. This dental program is designed to enhance the level of dental benefits that you currently receive. Your basic discounted dental coverage through the Plan is not affected by this enhanced product offering. This supplemental coverage is through Delta Dental, a national dental provider, and is only available to members of Kaiser Permanente.

Delta Premier, a table of allowances program, allows you to choose any licensed dentist; however, discounted pricing is available only through Delta's provider network. After you satisfy a deductible, Delta will pay a predetermined amount toward each covered service. You will not need to satisfy a deductible toward covered preventive services you receive. Delta Premier offers a full range of covered services: diagnostic, preventive, restorative, endodontics, periodontics, oral surgery, and both fixed and removable prosthodontics. Orthodontic coverage is not available. Covered services will be phased in over a three (3) year period.

Delta Premier is only available to you if you are enrolled in Kaiser Permanente's Plan for the FEHB. You do not need to purchase this program to receive the basic dental coverage included in the Plan. Premium payments should be made directly to Delta Dental. Payroll deduction is not available for this program. How to Enroll: An enrollment form for Delta Premier is included in your Kaiser Permanente enrollment kit. If you would wish more information on Delta Premier, please call Delta Dental at 800/932-0783.

Monthly Premiums:	
Self	\$18.45
Self and One Party	\$33.45
Family	\$52.45

Fitness Center Membership

In order to maximize your overall health and wellness, we also offer you discounted membership to area Fitness centers through GlobalFit. Joining a gym has never been easier -- or cheaper. With GlobalFit, you can choose from a variety of area fitness centers. To search for a health club near you or for more information, contact GlobalFit at (800) 294-1500 or visit them on the web at www.globalfit.com/Kaiser.

Health Education Classes

In order to aid members in their quest for better health, the Plan makes available a variety of general health education classes such as prenatal, weight management, smoking cessation and stress management classes. To take advantage of these services, a Member need only identify himself/herself as a Plan member by showing his/her ID card and pay the providers' fee at the time of service.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

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

Section 7 Filing a claim for covered services

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

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, hospital, and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380.

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

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Claims Department
P.O. Box 6233
Rockville, Maryland 20849-6233

Deadline for filing your claim

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

When we need more information

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

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for precertification/prior approval:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 East Jefferson Street, Rockville, MD 20852, Attn: Member Services Appeals Unit; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">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; andYour daytime phone number and the best time to call.

The disputed claims process – continued on next page

The disputed claims process (*continued*)

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

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

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

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or precertification/prior approval, then call us Monday through Friday at 301/468-6000 inside the Washington, DC metropolitan area or 800/777-7902 outside the Washington, DC metropolitan area. Our TTY is 301/879-6380. Weekends and holidays, please call 703/359-7878 inside the Washington, DC metropolitan area or 800/777-7904 outside the Washington, DC metropolitan area. Our weekend TDD numbers are 703/359-7616 or toll free at 800/700-4901. We will expedite our review; or
- b) We denied your initial request for care or precertification/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage”.

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in another plan’s Medicare Advantage plan to get your Medicare benefits.
- We offer a Medicare Managed Care Plan known as Kaiser Permanente Medicare Plus (an 1876 Medicare Cost Plan). Please review the information on coordinating benefits with a Medicare Managed Care Plan on the next page.
- Part D (Medicare prescription drug coverage). Most people pay monthly for a Prescription Drug Plan (PDP) under Medicare part D. If you are enrolled in Kaiser Permanente Medicare Plus, you will get all the benefits of Part D plus additional benefits because Part D is included in the plan. 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 our prescription drug coverage and Medicare. The notice is on the first page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

Please refer to the Medicare Plus Annual Notice of Change (ANOC) or Evidence of Coverage for the complete details of your additional benefits with Kaiser Permanente’s Medicare Plus plan, which now includes Part D.

- **Should I enroll in Medicare?**

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

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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

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

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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 probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan. We will not waive any of our copayments, coinsurance, or deductibles unless you enroll in Kaiser Permanente Medicare Plus.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, please call 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. If hearing impaired, our TTY telephone number is 301/879-6380.

- **Medicare Advantage (Part C)**

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

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

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 managed care Cost plan**

You may enroll in our Medicare managed care Cost plan known as Kaiser Permanente Medicare Plus. We offer Kaiser Permanente Medicare Plus at no additional cost to our members eligible for Medicare benefits including Part D, as well as lower copayments and coinsurance at no cost to you. If you have already enrolled and would like to understand your additional benefits in more detail, please refer to your Medicare Annual Notice of Change (ANOC). If you are considering enrolling in our Medicare Plus plan, please call Member Services at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. If hearing impaired, our TTY telephone number is 301/879-6380.

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

This health plan coordinates its prescription drug benefits with Medicare Part D. If you enroll in Medicare Part D, we will review claims for your prescription drug costs that are not covered by Medicare Part D.

If you enroll in a Part D Prescription Drug Plan (PDP), you can not get your PDP benefits in pharmacies owned and operated by Kaiser Permanente. We will review your prescription drug claims that are not covered by your PDP for payment in accordance with your Kaiser Permanente FEHB coverage. Please refer to page 54 of your brochure for additional information about your FEHB prescription drug coverage. If you enroll in our Medicare Plus plan, your Part D benefits are included and coordination of benefits will not be required.

Primary payer chart begins on next page.

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

Primary Payer Chart

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

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

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 the program.

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

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

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

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

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting, and taking medicine. (2) Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Custodial care that lasts 90 days or more is sometimes known as Long term care
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.
Durable medical equipment	Durable medical equipment (DME) is equipment that is intended for repeated use, medically necessary, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, designed for prolonged use, appropriate for use in the home, and serving a specific therapeutic purpose in the treatment of an illness or injury.
Experimental or investigational services	A service, supply, item or drug that (1) has not been approved by the FDA; or (2) is the subject of a new drug or new device application on file with the FDA; or (3) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or (4) is subject to the approval or review of an Institutional Review Board; or (5) requires an informed consent that describes the service as experimental or investigational.
Group health coverage	Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Health care coverage purchased through membership in an organization is also "group health coverage."
Medically necessary	All benefits need to be medically necessary in order for them to be covered benefits. Generally, if your Plan physician provides the service in accord with the terms of this brochure, it will be considered medically necessary. However, some services are reviewed in advance of your receiving them to determine if they are medically necessary. When we review a service to determine if it is medically necessary, a Plan physician will evaluate what would happen to you if you do not receive the service. If not receiving the service would adversely affect your health, it will be considered medically necessary. The services must be a medically appropriate course of treatment for your condition. If they are not medically necessary, we will not cover the services. In case of emergency services, the services that you received will be evaluated to determine if they were medically necessary.

Our allowance	The amount we use to determine your coinsurance. When you receive services or supplies from Plan providers, it is the amount that we set for the services or supplies if we were to charge for them. When you receive services from non-Plan providers, we determine the amount that we believe is usual and customary for the service or supply, and compare it to the charges. Our allowance is based upon the reasonableness of the charges. If the charges exceed what we believe is reasonable, you may be responsible for the excess over our allowance in addition to your coinsurance.
Your Primary care copayment	The copayment for your primary care department visit is \$10 for the High Option plan and \$30 for the Standard Option Plan for the following areas: internal medicine, obstetrics and gynecology, pediatrics and, family practice services.
Your Specialty care copayment	The copayment for your specialty care department visit is \$20 for the High Option plan and \$40 for the Standard Option plan. This copayment applies when you receive services from areas other than primary care (as defined above).
Us/We	Us and We refer to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

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

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

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

- **Children’s Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 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 2005 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

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

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

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12 Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – FSAFEDS

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return and who is mentally or physically incapable of self care.
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year.

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled during 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

- Online: visit www.fsafeds.com and click on Enroll.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAFEDS accounts. *However, if you enroll in an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

Almost all Federal employees are eligible to enroll for a DCFSAs. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “Use-it-or-Lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005 until March 15, 2006 to incur eligible expenses and, you may submit claims for those expenses through May 31, 2006.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized in Section 4 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the High Option of this plan, typical out-of-pocket expenses include: office visit copayments, prescription drug copayments, and durable medical equipment coinsurance.

Under the Standard Option of this plan, typical out-of-pocket expenses include: office visit copayments, prescription drug copayments, and durable medical equipment coinsurance.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at <https://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp>. If you do not see your service or expense listed please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. You must re-enroll every Open Season to remain in the paperless reimbursement program. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.FSAFEDS.com and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?** No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance during your period of coverage for the Plan Year plus 2 ½ month grace period, resulting in the forfeiture of funds remaining in your account (the IRS "Use-it-or-Lose-it" rule).
- **Contact us** To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time.
 - E-mail: FSAFEDS@shps.net
 - Telephone: 1-877-FSAFEDS (1-877-372-3337)
 - TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection** Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?
 - **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
 - **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
 - **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
 - **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
 - **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To request an Information Kit and application** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.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 the Kaiser Foundation Health Plan of the Mid-Atlantic States - 2006

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care department (nothing from infancy through age 4); \$20 specialty care department	20
Services provided by a hospital:		
• Inpatient	\$100 per admission copay	43
• Outpatient	\$50 per visit	45
Emergency benefits:		
• In-area and Out-of-area	\$50 per visit	49
Mental health & substance abuse treatment:	Regular cost sharing	51
Prescription drugs:		56
• Plan pharmacy	Generic drugs - \$10 per prescription/refill; Pref. Brand drugs - \$20 per prescription /refill; Non-Pref. Brand drugs - \$35 per prescription/refill	
• Retail pharmacy	Generic drugs - \$20 per prescription/refill; Pref. Brand drugs - \$40 per prescription/refill; Non-Pref. Brand drugs - \$55 per prescription/refill	
• Mail service delivery	Generic drugs - \$8 per prescription/refill; Pref. Brand drugs - \$18 per prescription/refill; Non-Pref. Brand drugs - \$33 per prescription/refill	
Dental care:	Various copayments based on procedure rendered	62
Vision care:	Refractions in Optometry; \$10 per office visit	32
Special features: Flexible benefits option; 24 hour nurse line; Services for deaf and hearing impaired; Centers of Excellence; Travel benefit; Services from other Kaiser Permanente Plans		59
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$1,750/Self Only or \$3,500/Family enrollment per year Some costs do not count toward this protection	16

Summary of benefits for the Standard Option of the Kaiser Foundation Health Plan of the Mid-Atlantic States - 2006

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

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$30 primary care department (nothing from infancy through age 4); \$40 specialty care department	20
Services provided by a hospital:		
• Inpatient	\$250 per day up to \$750 maximum per admission	43
• Outpatient	\$100 per visit	45
Emergency benefits:		
• In-area and Out-of-area	\$100 per visit	49
Mental health & substance abuse treatment:	Regular cost sharing	51
Prescription drugs:		56
• Plan pharmacy	Generic drugs - \$15 per prescription/refill; Pref. Brand drugs - \$25 per prescription/refill; Non-Pref. Brand drugs - \$40 per prescription/refill	
• Retail pharmacy	Generic drugs - \$25 per prescription/refill; Pref. Brand drugs - \$45 per prescription/refill; or Non-Pref. Brand drugs - \$60 per prescription/refill	
• Mail service delivery	Generic drug - \$13 per prescription/refill; Pref. Brand drugs - \$23 per prescription/refill; or Non-Pref. Brand drugs - \$38 per prescription/refill	
Dental care:	Various copayments based on procedure rendered	62
Vision care:	Refractions in Optometry; \$30 per office visit	32
Special features: Flexible benefits option; 24 hour nurse line; Services for deaf and hearing impaired; Centers of Excellence; Travel benefit; Services from other Kaiser Permanente Plans		59
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after \$3,000/Self Only or \$6,000/Family enrollment per year. Some costs do not count toward this protection	16

Notes

Notes

Notes

2006 Rate Information for Kaiser Foundation of the Mid-Atlantic States, Inc.

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

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

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

Type of Enrollment	Code	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Postal Premium</i>	<i>Postal Premium</i>
		<u>Biweekly</u>	<u>Biweekly</u>	<u>Monthly</u>	<u>Monthly</u>	<u>Biweekly</u>	<u>Biweekly</u>
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	E31	\$133.98	\$44.66	\$290.29	\$96.76	\$158.54	\$20.10
High Option Self and Family	E32	\$316.08	\$109.09	\$684.84	\$236.36	\$373.15	\$52.02
HDHP Self-Only	E34	\$80.36	\$26.79	\$174.12	\$58.04	\$95.10	\$12.05
HDHP Self and Family	E35	\$191.26	\$63.75	\$414.39	\$138.13	\$226.32	\$28.69