

Kaiser Foundation Health Plan of Georgia, Inc.

<http://kp.org/feds>



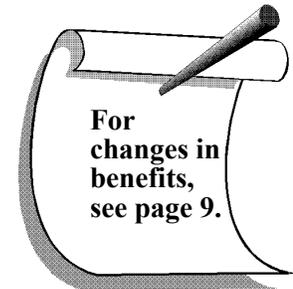
KAISER PERMANENTE®

2008

A Health Maintenance Organization (High and Standard Option) and a High Deductible Health Plan (HDHP)

Serving: Atlanta, Georgia metropolitan 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 2008 Guide for more information on accreditation.*

Enrollment codes for this Plan:

- F81 High Option – Self Only**
- F82 High Option – Self and Family**
- F84 Standard Option – Self Only**
- F85 Standard Option - Self and Family**
- GW1 High Deductible Health Plan (HDHP) – Self Only**
- GW2 High Deductible Health Plan (HDHP) – 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 73-321

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

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

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Introduction

This brochure describes the benefits of Kaiser Foundation Health Plan of Georgia, Inc. under our contract (CS 2163) 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 Georgia, Inc.'s administrative offices is:

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

This brochure is the official statement of benefits. No 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, 2008, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008, and changes are summarized on page 9. 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” or “Plan” means Kaiser Foundation Health Plan of Georgia, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean 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 fehwebcomments@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:

- Do not give your Plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOB) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 404/261-2590 and explain the situation.
 - If we do not resolve the issue:

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

OR WRITE TO:

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

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); 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.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.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. 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 see 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, a Standard Option, or a High Deductible Health Plan (HDHP).

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

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

Our HMO offers both a High and Standard Option. Under our High Option there are not any deductibles and you pay a copayment for most of your covered services. Under our Standard Option there are deductibles and many of the covered services are subject to coinsurance.

How we pay providers

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

General features of our High Deductible Health Plan (HDHP)

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

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small copayment. First dollar coverage may be limited to a maximum dollar amount each year.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

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

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

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$3,000 for Self Only enrollment, or \$6,000 for family coverage.

Health education resources and accounts management tools

There are a variety of health education resources and account management tools available to our members. We offer consumer decision support tools that are designed to assist members in determining if an HDHP is right for them. Account management tools are also available from Wells Fargo and SHPS that provide account balance and transaction history.

Consumer Decision Support

- Demonstration and Web tour of all systems available online
- Basic cost of care calculator

Account Management (available from Wells Fargo)

- Online HSA balance
- Online account transaction history
- Online frequently asked questions
- Online IRS Publication 502 that defines qualified medical expenses
- Online account maintenance documents and forms
- Online investment fund information and prospectus

Account Management (available from SHPS)

- Online HRA balance
- Online HRA Claims history
- Online frequently asked questions
- Online IRS Publication 502 that defines qualified medical expenses
- Online account maintenance documents and forms
- Electronic imaging of HRA claims (not medical claims)

Your rights

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

- Kaiser Foundation Health Plan of Georgia, Inc., a Georgia non-profit corporation, is a wholly owned subsidiary of Kaiser Foundation Health Plan, Inc. This Plan is part of the Kaiser Permanente Medical Care Program, a group of non-profit organizations and contracting medical groups that serve over 8 million members nationwide.
- In October 1985, Kaiser Permanente began operations in the State of Georgia. Kaiser Permanente is the state's largest non-profit health plan, providing health care to approximately 277,000 members in the metro-Atlanta area.
- In 2007, 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.
- All Kaiser Permanente affiliated hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the commission that sets nationally recognized health care standards for hospitals and other health care organizations.
- Kaiser Permanente reviews the credentials – including licensing, education, training, experience, health status, judgment, and office conditions – of physicians before they are selected to participate in our medical care program, and we review them on an ongoing basis.
- We credential Plan providers in accordance with national standards.
- Plan physicians are members of American Specialty Boards or are Board eligible.

If you want more information about us, call 404/261-2590, or write to Kaiser Permanente, Customer Service Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736. You may also contact us by visiting our Web site at <http://kp.org/feds>.

Your medical and claims records are confidential

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

Language Interpretation Services

You are entitled to free language services that include access to an interpreter and translation of key documents. To access a language service, notify the receptionist, your physician or any member of our nursing staff. For information about providers who speak foreign languages, call us at 404/365-0966.

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 includes these counties: Bartow, Barrow, Butts, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale, Spalding, and Walton.

Ordinarily, you must get your care from providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente or allied plan service area, you can receive visiting member care from designated providers in that area. See Section 5(h), Special Features, for more details. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described in Section 5(h); and for emergency care obtained from any non-Plan provider, as described in Section 5(d). 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 2008

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

Changes to this Plan

- United States Postal Service non-law enforcement career employees may now be covered either by Postal Category 1 or Postal Category 2 premium rates. See page 130.

Changes to High Option only

- Your share of the non-Postal premium will increase. See page 130.
- We have increased the copayment for specialty scans (CT, MRI, PET and nuclear medicine) from no charge to \$20 per office visit or \$75 per outpatient hospital visit. See page 22.
- We have increased the copayment for lab, x-rays and diagnostic tests received during outpatient hospital or ambulatory surgical center visit from no charge to \$75 per visit. See page 41.
- We have decreased the cost share for infertility diagnosis services from 50% of our allowance to \$20 per office visit. See page 25.
- We have decreased the copayment for an annual routine physical examination for adults and children from \$10 for primary care or \$20 for specialty care visits to no charge. See page 22.
- We have decreased the copayment for medication evaluation and management under mental health and substance abuse from \$20 to \$10 per office visit. See page 47.
- We have increased the copayment for brand name prescription drugs obtained at a plan medical office pharmacy from \$20 to \$25 per prescription or refill. We have increased the copayment for brand name prescription drugs obtained at a plan participating community from \$26 to \$31 per prescription or refill. See page 51.

Changes to Standard Option only

- Your share of the non-Postal premium will increase. See page 130.
- We have increased the catastrophic protection out-of-pocket maximum amount from \$2,000 per person or \$6,000 per family to \$2,500 per person or \$7,500 per family per calendar year. See page 16.
- We have increased the primary care provider office visit copayment from \$15 to \$20 and increased the specialty care provider office visit copayment from \$25 to \$30. See page 21.
- We have increased the urgent care center copayment from \$30 to \$40. See page 21.
- We have decreased the cost share for cardiac stress tests and nerve conduction studies performed during an office visit from 20% of our allowance after the calendar year deductible to \$30 per office visit. See page 21.
- We have decreased the copayment for an annual routine physical examination for adults and children from \$15 for primary care or \$25 for specialty care visits to no charge. See page 22.
- We have decreased the cost share for infertility diagnosis services from 50% of our allowance after the calendar year deductible to \$30 per office visit. See page 25.
- We have decreased the cost share for psychological testing under mental health and substance abuse from 20% of our allowance after the calendar year deductible to \$30 per office visit. See page 48.
- We have decreased the cost share for allergy testing and treatment received during an office visit from 20% of our allowance after the calendar year deductible to \$30 per office visit. See page 26.
- We have decreased the cost share for routine lab, x-rays and diagnostic tests received during an office visit from 20% of our allowance after the calendar year deductible to no charge. See page 22.

- We have decreased the copayment for medication evaluation and management under mental health and substance abuse from \$25 to \$20 per office visit. See page 47.
- We have increased the copayment for generic prescription drugs obtained at a plan medical office pharmacy from \$15 to \$20 and brand name prescription drugs from \$25 to \$30 per prescription or refill. We have increased the copayment for generic prescription drugs obtained at a plan participating community pharmacy from \$21 to \$26 and brand name drugs from \$31 to \$36 per prescription or refill. See page 51.

Changes to both High and Standard Options

- We have added coverage for hearing aids for children under the age of 18. This includes one hearing aid per ear every 36 months, limited to \$1,000 for each aid. See page 28.

Changes to our High Deductible Health Plan

- Your share of the non-Postal premium will increase. See page 130.
- We have added coverage for hearing aids for children under the age of 18. This includes one hearing aid per ear every 36 months, limited to \$1,000 for each aid. See page 76.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 404/261-2590 (locally), 888/865-5813 (long distance) or 800/255-0056 (TTY number), or write to us at Customer Service Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736. You may also request replacement cards through our Web site at <http://kp.org/feds>.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims.

- **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 Southeast Permanente Medical Group, Inc. (Plan physicians), an independent multi-specialty group of physicians, to provide or arrange all necessary physician care. Plan physicians, nurse practitioners, physician assistants, and other skilled medical personnel working as medical teams provide your health care services. Specialists consult with these medical teams in determining your treatment. Plan physicians refer patients to community specialists when necessary. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site at <http://www.kp.org/medstaffdirectory>.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. If you do not select a primary care physician upon enrollment, we will assist you by identifying a physician in a medical center near your home and including you in that physician’s panel of patients. This decision is important since your primary care physician provides or arranges for most of your health care. To learn how to choose or change your primary care physician, call our Customer Service Department at 404/261-2590 (locally), 888/865-5813 (long distance), or 800/255-0056 (TTY number).

- **Primary care**

Your primary care physician can be a family practitioner, general practitioner, internist, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. You may select your primary care physician from the Medical Group Physicians or from contracted private-practice Affiliated Community Physicians practicing in their own offices all over town. The Medical Group physicians provide care at Kaiser Permanente medical centers in our service area. An Affiliated Community Physician provides care in his or her own medical office. Adults should select an internal medicine, family practice, or general practice physician. Parents can choose a pediatrician, family practice, or general practice physician for their children. Note: Some family medicine physicians only treat adults. If you select a family medicine physician for your child, please make sure that physician treats children.

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.

To learn how to choose or change your primary care physician, call our Customer Service Department at 404/261-2590 (locally), 888/865-5813 (long distance) or 800/255-0056 (TTY number).

- **Specialty care**

Specialty care is care you receive in areas other than primary care (as defined above). Your primary care physician will refer you to a specialist for needed care. You will pay a different copayment for your specialty care. When you receive a 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 authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a gynecologist, a dermatologist, an optometrist, an ophthalmologist or mental health and substance abuse Plan providers without a referral.

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

- Keep in mind that your primary care physician choice determines which specialists are available to you. Your primary care physician has an established relationship with a specific group of specialty care doctors. By referring only to a certain group of specialists, your primary care physician is better able to ensure that you receive quality 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 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 other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

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

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

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

• **If you are hospitalized when your enrollment begins** We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 404/261-2590. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

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, medically necessary, and follows generally accepted medical practice.

We call this review and approval process preauthorization. Your physician must obtain preauthorization for the following services. This list is subject to change. For the most current information, call our Customer Service Department at 404/261-2590.

- All inpatient hospital care services (this does not apply to emergency admissions)
- Skilled nursing care benefits
- Inpatient mental health or substance abuse services
- Inpatient rehabilitation therapy services or programs
- Organ and tissue transplants
- Bariatric surgery
- Infertility procedures
- Certain outpatient procedures and services:
 - Certain ambulatory surgery
 - Biofeedback or other pain management treatment
 - Breast augmentation/reduction
 - Drugs: Botox injections, Byetta, Human Growth Hormone, Symlin, and Xolair
 - Certain durable medical equipment, and orthopedic and prosthetic devices
 - Epidural steroid injections
 - Home Health Care

- Hospice care
- Hyperbaric oxygen (HBO) treatment
- Implantable cardioverter defibrillators (ICD)
- Intrathecal and epidural infusion pumps
- PET Scans
- Sclerotherapy or other varicose vein treatment
- Speech therapy
- Spinal cord stimulation
- Uvulopalatopharyngoplasty
- Any request for non-Plan providers

Section 4. Your cost for covered services

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

Copayments

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

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

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

- Under the High Option Plan, you pay a \$10 copayment when you receive diagnostic and treatment services from a primary care provider and a \$20 copayment when you receive these services from a specialty care provider.
- Under the Standard Option Plan, you pay a \$20 copayment when you receive diagnostic and treatment services from a primary care provider and a \$30 copayment when you receive these services from a specialty care provider.
- Under the HDHP, you pay a \$15 copayment when you see your primary care physician for routine physical exams once every 12 months.

Cost-sharing

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

Deductible

High Option Plan:

We do not have a deductible in the High Option Plan.

Standard Option Plan:

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

- The calendar year deductible for the Standard Option Plan is \$500 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$1,500.

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

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

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

HDHP:

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

The calendar year deductible for the HDHP is \$1,100 for Self Only enrollment or \$2,200 for family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin. Preventive care services are not subject to the deductible. You only owe your copayment and coinsurance for certain covered preventive care services.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

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

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 \$20 charge for each bill sent for unpaid services. Affiliated Community Physicians may bill you an additional charge along with any unpaid copayments or coinsurance.

Missed appointment fee

You must give at least 24-hours notice to your Plan provider if you are unable to keep your scheduled appointment. If you do not, you may be required to pay an administrative fee of \$25 or pay for services that were specifically arranged for your visit as well as the cost of any drugs and supplies that were prepared for your appointment and that cannot be reused.

Note: Affiliated physician offices 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

High Option Plan:

We do not have a catastrophic protection out-of-pocket maximum in the High Option Plan.

Standard Option Plan:

After your copayments and coinsurance total \$2,500 per person or \$7,500 per family enrollment in any calendar year, you do not have to pay any more for certain covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must pay copayments and coinsurance for these services even after your expenses exceed the limits described above:

- Any services for which you pay a copayment (except inpatient hospital facility)
- Expenses in excess of our allowable amount or maximum benefit limitations
- Expenses for infertility treatment services
- Expenses for dental services
- Fees or administrative charges
- Any non-FEHB benefits

Note: The calendar year deductible does not count toward your catastrophic protection out-of-pocket maximum.

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

HDHP:

After your copayments, coinsurance and deductible total \$3,000 for Self Only enrollment or \$6,000 for family enrollment in any calendar year, you do not have to pay any more for certain covered services.

Carryover

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

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

When Government facilities bill us

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

Section 5. High and Standard Option Benefits

See page 9 for how our benefits changed this year. Page 124 and page 125 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 404/261-2590 or at our Web site at <http://kp.org/feds>.

For 20 years, Kaiser Permanente of Georgia has been a leader in offering high quality integrated health care to the communities we serve. What differentiates Kaiser Permanente of Georgia from other HMO's and helps us contain costs is that we approach health care not as an industry, but as a cause. As part of our continued commitment to keep pace with your healthcare needs, we have enhanced our care management programs to include "Whole Person" health coaching. Members can now enjoy one-on-one health coaching, in addition to having access to the acclaimed Southeast Permanente Medical Group, Inc. and 1,000 affiliated private practice physicians.

Our seamless delivery system provides convenient, comprehensive care all under one roof. You can come to any one of our 12 medical facilities and see your primary care physician, pediatrician, Ob/Gyn, and other specialists, 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, send secure messages to your provider, refill prescriptions, research medical conditions and soon, view your medical information on line.

In 2007, The Kaiser Permanente 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, Kaiser Permanente of Georgia offers two benefit Plans to the Federal employees, the High and Standard Options. Both options are designed to include preventive and acute care services provided by our Plan providers. The options offer different levels of benefits and services for you to choose between to best fit your health care needs.

Each option offers unique features.

High Option

Our High Option provides the most comprehensive benefits. There is no calendar year deductible. You pay a copayment for most covered services. You get high quality, personalized care with The Southeast Permanente Medical Group, Inc. and 1,000 affiliated private practice physicians on both the High and Standard Options.

Standard Option

With the Standard Option there is a calendar year deductible of \$500 per person (\$1500 per family) and your copayments and coinsurance may be higher than for the High Option, however your bi-weekly premium is lower.

Additional Benefits – Dental

Please note, with either Kaiser Permanente Plan option you automatically receive preventive dental plan benefits as described in Section 5(g), administered by Delta Dental, Inc. For more extensive dental benefits you may also choose the voluntary comprehensive dental benefits through the DeltaCare Dental Program, administered by PMI Dental Health Plan (PMI) as described in Section 5, Non-FEHB benefits available to Plan members.

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Under Standard Option - The calendar year deductible is \$500 per person (\$1,500 per family). The calendar year deductible and Plan coinsurance apply to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Under High Option – We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Different copayments apply for primary care visits and specialty care visits in the Standard and High Option Plans. Please refer to Section 10, Definitions, to learn more about when your primary and specialty care copayments will apply.
- **YOU MUST GET PREAUTHORIZATION FOR SOME MEDICAL PROCEDURES.** Please refer to the preauthorization list shown in Section 3 to be sure which services and supplies require preauthorization.

Benefit Description	You pay After the calendar year deductible...	
<p>Note: The Standard Option Plan calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>		
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • Second surgical opinion 	\$10 per primary care office visit \$20 per specialty care office visit	\$20 per primary care office visit \$30 per specialty care office visit (No deductible)
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • To receive injections 	\$10 per office visit	\$10 per office visit (No deductible)
<ul style="list-style-type: none"> • In an urgent care center 	\$20 per office visit	\$40 per office visit (No deductible)
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing	20% of our allowance after you have met your calendar year deductible
Certain procedures received during an office visit, such as: <ul style="list-style-type: none"> • Cardiac stress tests • Nerve conduction studies 	Nothing	\$30 per office visit (No deductible)

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Diagnostic and treatment services (cont.)	High Option	Standard Option
At home	Nothing	Nothing (No deductible)
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound 	Nothing	Nothing (No deductible)
• CT Scans, MRI, PET scans, nuclear medicine	\$20 per office visit	20% of our allowance after you have met your calendar year deductible
• Electrocardiogram and EEG	Nothing	Nothing (No deductible)
Preventive care, adult	High Option	Standard Option
Routine physical once every 12 months	Nothing	Nothing (No deductible)
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Routine Pap test <p>Note: You do not pay a separate copayment for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i>, above.</p>	Nothing	Nothing (No deductible)
Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Colonoscopy screening – every ten years starting at age 50 	\$75 per visit	20% of our allowance after you have met your calendar year deductible
- Double contrast barium enema – every five years starting at age 50	Nothing	20% of our allowance after you have met your calendar year deductible
- Fecal occult blood test	Nothing	Nothing
- Sigmoidoscopy, screening – every five years starting at age 50	Nothing	(No deductible)
Notes: <ul style="list-style-type: none"> • You should consult with your physician to determine what screenings are appropriate for you. 		

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Preventive care, adult (cont.)		
<ul style="list-style-type: none"> You pay only one copayment if you receive your routine screening on the same day as your office visit. 		
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> From age 35 through 39, one during this five year period From age 40 through 64, one every calendar year At age 65 and older, one every two consecutive calendar years 	Nothing	Nothing (No deductible)
<ul style="list-style-type: none"> Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) 	Nothing if you receive these services during your office visit; otherwise \$10 per visit.	Nothing if you receive these services during your office visit; otherwise \$20 per visit. (No deductible)
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment, insurance or licensing; participating in employee programs; attending schools or camp; travel; or court order required for parole or probation.</i>	<i>All charges</i>	<i>All charges</i>
Preventive care, children	High Option	Standard Option
<ul style="list-style-type: none"> Well-child preventive care charges for routine examinations, immunizations and care (up to age 18) 	Nothing	Nothing (No deductible)
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing if you receive these services during your office visit; otherwise \$10 per visit.	Nothing if you receive these services during your office visit; otherwise \$20 per visit. (No deductible)
Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) 	\$10 per office visit	\$20 per office visit (No deductible)
<i>Not covered: Physical exams required for obtaining or continuing employment, insurance or licensing; participating in employee programs; attending schools or camp; travel; or court order required for parole or probation.</i>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Maternity care		
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Routine prenatal care visits (obstetrician, nurse midwife, and OB nurse practitioner) • First postnatal care visit 	Nothing	Nothing (No deductible)
<ul style="list-style-type: none"> • All other visits during pregnancy (such as visits to genetics counselors and perinatologists) 	\$20 per office visit	\$30 per office visit (No deductible)
<ul style="list-style-type: none"> • Delivery <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. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay surgeon services (delivery) and hospitalization the same as for illness and injury. See Surgery benefits (Section 5(b)) and Hospital benefits (Section 5(c)). 	Nothing	20% of our allowance after you have met your calendar year deductible (See Section 5 (c) for Hospital charges)
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges</i>	<i>All charges</i>
Family planning	High Option	Standard Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover surgically implanted contraceptives, diaphragms, injectable contraceptive drugs, intrauterine devices (IUDs) and oral contraceptives under the prescription drug benefit. See Prescription drug benefits (Section 5(f)).</p>	<p>\$10 per primary care office visit</p> <p>\$20 per specialty care office visit</p>	<p>\$20 per primary care office visit</p> <p>\$30 per specialty care office visit</p> <p>(No deductible)</p> <p>20% of our allowance for surgical procedures after you have met your calendar year deductible</p>

Family planning - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Family planning (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Voluntary sterilization (See Surgical procedures Section 5 (b)) 	\$75 per visit	\$20 per primary care office visit \$30 per specialty care office visit (No deductible) 20% of our allowance for surgical procedures after you have met your calendar year deductible
<i>Not covered:</i> <ul style="list-style-type: none"> Reversal of voluntary surgical sterilization Genetic counseling 	<i>All charges</i>	<i>All charges</i>
Infertility services	High Option	Standard Option
Diagnosis of infertility such as: <ul style="list-style-type: none"> Visits for diagnosis of involuntary infertility 	\$20 per office visit	\$30 per office visit (No deductible)
Treatment of involuntary infertility <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 medical benefits and oral fertility drugs under the prescription drug benefit. See Section 5(f).</p>	50% of our allowance	50% of our allowance (No deductible)
<i>Not covered:</i> <p><i>Assisted reproductive technology (ART) procedures, such as:</i></p> <ul style="list-style-type: none"> <i>In vitro fertilization</i> <i>Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> <i>Services and supplies related to ART procedures</i> <i>Cost of donor sperm</i> <i>Cost of donor egg.</i> <i>Semen or eggs, and services and supplies related to their procurement and storage.</i> 	<i>All charges</i>	<i>All charges</i>

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Infertility services (cont.)		
Notes: <ul style="list-style-type: none"> • These exclusions apply to fertile as well as infertile individuals or couples. • Infertility services are not available when either member of the couple has been voluntarily surgically sterilized. 	<i>All charges</i>	<i>All charges</i>
Allergy care	High Option	Standard Option
• Testing and treatment	\$20 per office visit	\$30 per office visit
• Allergy injections	\$10 per office visit	\$10 per office visit (No deductible)
• Allergy serum	Nothing	Nothing (No deductible)
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>	<i>All charges</i>
Treatment therapies	High Option	Standard Option
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants in Section 5(b).	\$20 per office visit	\$30 per office visit (No deductible)
• Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit and requires preauthorization. See <i>Services requiring our preauthorization</i> in Section 3.	\$20 per office visit	\$30 per office visit (No deductible)
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing at home \$20 per office visit	Nothing at home \$30 per office visit (No deductible)
<i>Not covered: Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered.</i>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Physical and occupational therapies		
<p>Up to 20 visits per condition per calendar year for the services of:</p> <ul style="list-style-type: none"> • Qualified physical therapists • Occupational therapists <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 weeks or 36 visits</p> <p>Notes:</p> <ul style="list-style-type: none"> • We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. • We cover occupational therapy to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life. 	<p>\$20 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p>	<p>20% of our allowance after you have met your calendar year deductible</p>
<ul style="list-style-type: none"> • Comprehensive outpatient rehabilitation facility services 	<p>Nothing</p>	<p>20% of our allowance after you have met your calendar year deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> • <i>Cognitive rehabilitation programs</i> • <i>Vocational rehabilitation programs</i> • <i>Therapies done primarily for educational purposes</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Speech therapy		
<ul style="list-style-type: none"> • Up to 20 visits per condition per calendar year 	<p>\$20 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p>	<p>20% of our allowance after you have met your calendar year deductible</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"> • <i>Therapy for educational placement or other educational purposes</i> • <i>Training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation</i> • <i>Therapy for tongue thrust in the absence of swallowing problems</i> • <i>Voice therapy for occupation or performing arts</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...	
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> Hearing testing to determine the need for hearing correction 	\$20 per office visit	\$30 per office visit (No deductible)
<ul style="list-style-type: none"> Audiometric exams 	\$20 per office visit	20% of our allowance after you have met your calendar year deductible
<ul style="list-style-type: none"> Hearing aids, including testing and examinations for them, for children under age 18 	All charges in excess of \$1,000 for each hearing impaired ear every 36 months	All charges in excess of \$1,000 for each hearing impaired ear every 36 months
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> All other hearing testing Hearing aids, including testing and examinations for them for all persons age 18 and over 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> Diagnosis and treatment of diseases of the eye Annual eye refractions (to provide written lens prescription) <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	\$20 per office visit	\$30 per office visit (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Corrective eyeglasses and frames or contact lenses (including the examination and fitting of contact lenses) Refractions for contact lenses Eye exercises, orthoptics and visual training Radial keratotomy and other refractive surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism Low vision aids 	<i>All charges</i>	<i>All charges</i>
Foot care	High Option	Standard Option
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	\$10 per primary care office visit \$20 per specialty care office visit	\$20 per primary care office visit \$30 per specialty care office visit (No deductible)
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>

Foot care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Foot care (cont.)	High Option	Standard Option
<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	High Option	Standard Option
<p>External prosthetic and orthotic devices, such as:</p> <ul style="list-style-type: none"> • Ostomy and urological supplies • Artificial limbs and eyes; stump hose • Braces • Therapeutic shoes required for conditions associated with diabetes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Scoliosis braces • Lenses following cataract removal • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	20% of our allowance	20% of our allowance after you have met your calendar year deductible
<p>Internal prosthetic devices, such as artificial joints, pacemakers, intraocular lens following cataract removal, cochlear implants, and surgically implanted breast implant following mastectomy.</p> <p>Note: See 5(b) for coverage of the surgery to insert the device.</p>	Nothing	Nothing (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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>Experimental or research equipment</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME)	High Option	Standard Option
<p>When prescribed by a Plan physician, we cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Infant apnea monitors; • Oxygen-dispensing equipment; • Blood glucose monitors; and • Insulin pumps. <p>Notes:</p> <ul style="list-style-type: none"> • Durable medical equipment (DME) is equipment that is prescribed by a Plan physician and is intended for repeated use, medically necessary, primarily and customarily used to serve a medical purpose, generally useful only to a person who is ill or injured, designed for prolonged use, appropriate for use in the home, and serves a specific therapeutic purpose in the treatment of an illness or injury. • 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>20% of our allowance</p>	<p>20% of our allowance after you have met your calendar year deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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>Devices for testing blood or other body substances</i> • <i>Electronic monitors of bodily functions, except apnea monitors and blood glucose monitors</i> • <i>Disposable supplies</i> • <i>Replacement of lost equipment</i> • <i>Repair, adjustments or replacements necessitated by misuse</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <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>Spare or alternate use equipment</i> • <i>Experimental or research equipment</i> 	<i>All charges</i>	<i>All charges</i>
Home health services	High Option	Standard Option
<p>If you are homebound and reside in the service area:</p> <ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), home health aide, physical or occupational therapist, and speech and language pathologist. • Services include oxygen therapy, intravenous therapy and medications. <p>Notes:</p> <ul style="list-style-type: none"> • Your Plan physician will periodically review the program for continuing appropriateness and need. • These 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 (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Private duty nursing</i> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> • <i>Custodial care</i> • <i>Care that the Plan determines may be appropriately provided in a Plan hospital, medical center, medical office, skilled nursing facility or other facility designated by Health Plan and we provide, or offer to provide, that care in one of these facilities.</i> • <i>Services outside our service area</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Chiropractic		
<p>Chiropractic services up to 30 visits per calendar year:</p> <ul style="list-style-type: none"> • Evaluation and management of musculoskeletal disorders • Manipulation of the spine and extremities • Routine chiropractic X-rays provided in the chiropractor's office (not to exceed 4 views) • Chiropractic adjustments • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and other appropriate therapies (e.g., hot and cold pack applications) not to exceed 2 per visit <p>Note: You may see a chiropractor without a referral from your Plan physician. Services must be provided from our list of Participating Chiropractors. Please contact us to get the list.</p>	\$20 per office visit	Not Covered
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Vitamins and supplements</i> • <i>Vax-D</i> • <i>Structural supports</i> • <i>Massage therapies</i> • <i>Maintenance/preventive care</i> • <i>Acupuncture therapy</i> • <i>Physical, speech and occupational therapy provided by a chiropractor</i> • <i>Neurological testing, unless authorized by your primary care physician</i> • <i>Laboratory and pathology services, unless authorized by your primary care physician</i> 	<i>All charges</i>	<i>All charges</i>
Alternative treatments	High Option	Standard Option
No benefit	<i>All charges</i>	<i>All charges</i>
Educational classes and programs	High Option	Standard Option
Training in self-care and preventive care	\$10 per office visit	\$20 per office visit
Health education publications and education about how to use our services and supplies	Nothing	Nothing
General health education not addressed to a specific condition, as well as Lamaze classes and weight control	Various charges	Various charges

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Educational classes and programs (cont.)</p> <p>Quit Smart Smoking Cessation Program: This program includes six sessions with one follow up session, lectures, a quit smoking kit, discussions and relaxation techniques, a patented realistic cigarette substitute and discount vouchers for nicotine replacement patches.</p> <p>Healthy Solutions Program: This program provides free phone-based health coach services from an experienced health care professional 24 hours a day.</p> <p>Health Media BREATHE Program: This program provides free web-based interactive tobacco cessation programs via our website (www.kp.org) 24 hours a day.</p> <p>Georgia Tobacco Quit Line: The Quit Line is a toll-free telephone resource for people who want to quit using tobacco. Callers will receive screening, counseling and referrals to resources and written materials. Friends and family members can call to get information about how to help their loved ones quit.</p>	Nothing	Nothing
Any member who is enrolled and attends the Quit Smart Smoking Cessation Program or enrolls in the Quit Line telephone counseling program is eligible to receive a two-week supply of nicotine replacement patches (with discount voucher) at a Plan pharmacy.	\$5	\$5
Any member who is enrolled and attends the Quit Smart Smoking Cessation Program or enrolls in the Quit Line telephone counseling program is eligible to receive a one-month supply of Bupropion SR (with discount voucher) at a Plan pharmacy. A prescription from a Plan physician is required.	\$40	\$40
Note: This information is a summary of services available. Please call us at 404/261-2590 for availability and location of these classes.		

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. Consult with your physician to determine what is appropriate for you. Services may be covered provided that established Plan physicians' criteria are met.
- Under Standard Option - The calendar year deductible is \$500 per person (\$1,500 per family). The calendar year deductible and Plan coinsurance apply to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Under High Option – We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option Plan calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	High Option	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 • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) 	\$20 per visit with specialist Nothing for hospital or ambulatory surgical center physician and professional services See Section 5(c) for facility charges.	\$30 per visit with specialist (No deductible) 20% of our allowance for outpatient and inpatient surgery and procedures after you have met your calendar year deductible See Section 5(c) for facility charges.

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery). You must: <ul style="list-style-type: none"> - be 18 years of age or older; and - have a Body Mass Index (BMI) greater than 40; or a BMI greater than 35 with another severe or life threatening condition such as: sleep apnea, cardiomyopathy or severe diabetes; and - have weight control failure; and - have made a commitment to a long term weight management plan and a behavioral health and nutrition assessment; and - have no untreated metabolic cause of obesity <p>Notes:</p> <ul style="list-style-type: none"> • You will need to meet the above qualifications before your Plan provider will refer you to our bariatric surgery program. This program may refer you to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including: <ul style="list-style-type: none"> - nutritional, - psychological, - medical; and - social readiness for surgery. • Final approval for surgical treatment will be required from The Southeast Permanente Medical Group's designated physician. See Section 3, <i>Services requiring our prior approval</i>, for more information. 	<p>\$20 per visit with specialist</p> <p>Nothing for hospital or ambulatory surgical center physician and professional services</p> <p>See Section 5(c) for facility charges.</p>	<p>\$30 per visit with specialist</p> <p>(No deductible)</p> <p>20% of our allowance for outpatient and inpatient surgery and procedures after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>
<ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See 5(a), <i>Orthopedic and prosthetic devices</i>, for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Surgically implanted of time-release contraceptives and other drugs and insertion of intrauterine devices (IUDs). • Treatment of burns <p>Notes:</p> <ul style="list-style-type: none"> • We cover the cost of these surgically implanted time-release contraceptive drugs and intrauterine devices under the prescription drug benefit (see Section 5(f)). 	<p>\$20 per visit with specialist</p> <p>Nothing for hospital or ambulatory surgical center physician and professional services</p> <p>See Section 5(c) for facility charges.</p>	<p>\$30 per visit with specialist</p> <p>(No deductible)</p> <p>20% of our allowance for outpatient and inpatient surgery and procedures after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. 	<p>\$20 per visit with specialist</p> <p>Nothing for hospital or ambulatory surgical center physician and professional services</p> <p>See Section 5(c) for facility charges.</p>	<p>\$30 per visit with specialist</p> <p>(No deductible)</p> <p>20% of our allowance for outpatient and inpatient surgery and procedures after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary sterilization</i> 	<i>All charges</i>	<i>All charges</i>
Reconstructive surgery	High Option	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"> the condition produced a major effect on the member's appearance; and the condition can reasonably be expected to be corrected by such surgery Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. Surgery for treatment of a form of congenital hemangioma known as port wine stains on the face of members 18 years or younger All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> surgery and reconstruction on the other breast to produce a symmetrical appearance; treatment of any physical complications, such as lymphedemas; breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <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 with specialist</p> <p>Nothing for hospital or ambulatory surgical center physician and professional services</p> <p>See Section 5(c) for facility charges</p>	<p>\$30 per visit with specialist</p> <p>(No deductible)</p> <p>20% of our allowance for outpatient and inpatient surgery and procedures after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>
<p><i>Not covered:</i></p>	<i>All charges</i>	<i>All charges</i>

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Reconstructive surgery (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>	<i>All charges</i>
Oral and maxillofacial surgery	High Option	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 temporomandibular joint (TMJ) disorder (non-dental); and • Other surgical procedures that do not involve the teeth or their supporting structures, except extraction of the teeth to prepare the jaw for radiation treatment of neoplastic disease. 	<p>\$20 per visit with specialist</p> <p>Nothing for hospital or ambulatory surgical center physician and professional services</p> <p>See Section 5(c) for facility charges</p>	<p>\$30 per visit with specialist</p> <p>(No deductible)</p> <p>20% of our allowance for outpatient and inpatient surgery and procedures after you have met your calendar year deductible</p> <p>See Section 5(c) for facility 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)</i> • <i>Shortening of the mandible or maxillae for cosmetic purposes</i> • <i>Correction of any malocclusion not listed above</i> • <i>Dental services associated with medical treatment such as surgery, except for services related to accidental injury of teeth (See Section 5(g))</i> 	<i>All charges</i>	<i>All charges</i>
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ tissue transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney 	<p>\$20 per visit with specialist</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges</p>	<p>\$30 per visit with specialist</p> <p>(No deductible)</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Organ/tissue transplants (cont.)		
<ul style="list-style-type: none"> • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas 	<p>\$20 per visit with specialist</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges</p>	<p>\$30 per visit with specialist</p> <p>(No deductible)</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the diagnosis and staging description.)</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	<p>\$20 per visit with specialist</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges</p>	<p>\$30 per visit with specialist</p> <p>(No deductible)</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges</p>
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogenic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors <p>Limited Benefits – Autologous blood or bone marrow stem cell transplants for breast cancer and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-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>\$20 per visit with specialist</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges</p>	<p>\$30 per visit with specialist</p> <p>(No deductible)</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
Notes: <ul style="list-style-type: none"> • We cover related medical and hospital expenses of the donor when we cover the recipient. • Please refer to Section 5(h) <i>Special features</i> for information on our Centers of Excellence. 		
<i>Not covered:</i> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of non-human or artificial organs • Transplants not listed as covered 	<i>All charges</i>	<i>All charges</i>
Anesthesia	High Option	Standard Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing	20% of our allowance after you have met your calendar year deductible

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Under Standard Option – The calendar year deductible is \$500 per person (\$1,500 per family). The calendar year deductible and Plan coinsurance apply to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Under High Option – We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR ALL NON-EMERGENCY INPATIENT HOSPITAL CARE SERVICES (except for maternity stays).** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option Plan calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Inpatient hospital	High Option	Standard Option
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$250 per admission	\$250 per day up to \$750 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services 	\$250 per admission	\$250 per day up to \$750 per admission

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Inpatient hospital (cont.)	High Option	Standard Option
<p>Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The need for anesthesia, by itself, is not such a condition.</p>	\$250 per admission	\$250 per day up to \$750 per admission
<ul style="list-style-type: none"> • Medical supplies and equipment, including oxygen, and any covered items billed by a hospital for use at home 	According to the benefit of the specific item you take home, i.e., hospital bed, pharmacy items, etc.	According to the benefit of the specific item you take home, i.e., hospital bed, pharmacy items, etc.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care and care in an intermediate care facility</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, and guest meals and beds</i> • <i>Private nursing care, except when medically necessary</i> • <i>Inpatient dental procedures</i> • <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient</i> 	<i>All charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	High Option	Standard Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Lab, X-ray, and other diagnostic tests • Blood and blood products • Pre-surgical testing • Dressings, casts, and sterile trays • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. See Section 5 (h) for dental information.</p>	\$75 per visit	20% of our allowance after you have met your calendar year deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...	
Skilled nursing care facility benefits	High Option	Standard Option
<p>Up to 100 days per calendar year when you need full-time nursing care.</p> <p>All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Room and board • General nursing care • Medical social services • Prescribed drugs, biologicals, supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility 	Nothing	Nothing (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care and care in an intermediate care facility</i> • <i>Personal comfort items, such as telephone, television, barber services, and guest meals and beds</i> 	<i>All charges</i>	<i>All charges</i>
Hospice care	High Option	Standard Option
<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 the home, when a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home. <p>Services include inpatient care under limited circumstances, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less.</p>	Nothing	Nothing (No deductible)

Hospice care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Hospice care (cont.)	High Option	Standard Option
<p>Note: Hospice is a program for caring for the terminally ill patient that emphasizes supportive services, such as home care and pain and symptom control, rather than curative care. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, therapy services for purposes of safety and symptom control, physician services, palliative drugs in accord with our drug formulary guidelines, durable medical equipment (DME), and short-term inpatient care for pain control and acute and chronic symptom management. We also provide inpatient respite care, counseling and bereavement services. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.</p>	Nothing	Nothing (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing (private duty nursing)</i> • <i>Homemaker services</i> 	<i>All charges</i>	<i>All charges</i>
Ambulance	High Option	Standard Option
<ul style="list-style-type: none"> • Local licensed ambulance service when medically necessary <p>Note: See Section 5(d) for emergency services</p>	\$75 per trip	\$125 per trip (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider</i> 	<i>All charges</i>	<i>All charges</i>

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under Standard Option - The calendar year deductible is \$500 per person (\$1,500 per family). The calendar year deductible and Plan coinsurance do not apply to benefits in this Section.
- Under High Option – We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

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

Emergencies within our service area:

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

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

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

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. Post stabilization care is the service you receive after your treating physician determines that you are clinically stable. We cover post-stabilization care if a Plan provider provides it or if you obtain authorization from us to receive the care from a non-Plan provider.

Emergencies outside our service area:

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

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

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 Customer Service Department in the Atlanta area at 404/261-2590, or from other areas at 888/865-5813.

Benefit Description	You pay After the calendar year deductible...	
Emergency within our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at an urgent care center not designated by the Plan Emergency care as an outpatient at a hospital, including physicians' services <p>Notes:</p> <ul style="list-style-type: none"> We waive your emergency room copayment if you are directly admitted to a hospital as an inpatient from the emergency room. Your inpatient admission copayment will still apply (See Section 5(c)). Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency copayment will not be waived. 	\$75 per visit	\$125 per visit (No deductible)
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at an urgent care center not designated by the Plan Emergency care as an outpatient at a hospital, including physicians' services <p>Notes:</p> <ul style="list-style-type: none"> We waive your emergency room copayment if you are directly admitted to a hospital from the emergency room. Your inpatient hospital copayment will still apply (See Section 5(c)). Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency copayment will not be waived. See Section 5(h) for travel benefit coverage of continuing or follow-up care. 	\$75 per visit	\$125 per visit (No deductible)
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
<ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</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> 		

High and Standard Option Option

Benefit Description	You pay After the calendar year deductible...	
Ambulance	High Option	Standard Option
<p>Licensed ambulance service when medically necessary.</p> <p>Notes:</p> <ul style="list-style-type: none"> • See Section 5(c) for non-emergency service. • Trip means any time an ambulance is summoned on your behalf. 	\$75 per trip	\$125 per trip (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Trips we determine are not medically necessary</i> • <i>Transportation by car, taxi, bus, gurney van, wheelchair van, minivan and any other type of transportation, even if it is the only way to travel to a provider or facility</i> 	<i>All charges</i>	<i>All charges</i>

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.

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.
- Under Standard Option – The calendar year deductible is \$500 per person (\$1,500 per family). The calendar year deductible and Plan coinsurance apply to almost all benefits in this Section. We added “(No deductible)” to show when a deductible does not apply.
- Under High Option –We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR INPATIENT SERVICES.**

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option Plan calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Mental health and substance abuse benefits	High Option	Standard Option
<p>We cover all diagnostic and treatment services recommended by a Plan mental health or substance abuse provider and contained in a treatment plan that we approve. 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 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 mental health or substance abuse 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 plan 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>
<ul style="list-style-type: none"> • Diagnosis and treatment of psychiatric conditions, mental illness, or disorders. Services include: <ul style="list-style-type: none"> - Medication evaluation and management 	<p>\$10 per office visit for individual therapy</p>	<p>\$20 per office visit for individual therapy</p>
<ul style="list-style-type: none"> - Diagnostic tests - Crisis intervention and stabilization for acute episodes - Treatment and counseling (including group and individual therapy visits) 	<p>\$20 per office visit for individual therapy</p> <p>\$10 per visit for group therapy</p>	<p>\$30 per office visit for individual therapy</p> <p>\$15 per visit for group therapy</p> <p>(No deductible)</p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Diagnosis and treatment of alcoholism and drug abuse. Services include: <ul style="list-style-type: none"> - Detoxification (medical management of withdrawal from the substance) - Treatment and counseling (including individual and group therapy visits) - Rehabilitative care 	\$20 per office visit for individual therapy \$10 per visit for group therapy	\$30 per office visit for individual therapy \$15 per visit for group therapy (No deductible)
<ul style="list-style-type: none"> • Psychological testing to determine the appropriate psychiatric treatment 	\$20 per office visit	\$30 per office visit
Notes: <ul style="list-style-type: none"> • You may see a Plan mental health or substance abuse provider for these services without a referral from your primary care physician. See Section 3, <i>How you get care</i>, for information about services requiring our prior approval. • Your Plan mental health or substance abuse provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you. 		
<ul style="list-style-type: none"> • Services provided in a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	Nothing for inpatient professional services See Section 5(c) for facility charges	20% of our allowance for inpatient professional services after you have met your calendar year deductible See Section 5(c) for facility charges.
Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan mental health or substance abuse physician.		
<i>Not covered:</i> <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 disorders 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>All charges</i>	<i>All charges</i>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <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</i> 	<i>All charges</i>	<i>All charges</i>

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 to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 51.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year pharmacy deductible.
- Your physician must get preauthorization for certain drugs. Certain prescription drugs require approval prior to dispensing. The list of prescription drugs that require preauthorization is subject to periodic review and modification. If you would like to know if a drug requires preauthorization you may contact our Customer Service Department at 404/261-2590.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription?** A Plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan medical office pharmacy or a Plan participating community pharmacy.

It may be possible for you to receive certain refills by mail at no extra charge. You can order prescription refills for mail delivery three ways:

1. Online, using our Members Only Web site at <http://kp.org/feds>. This site requires online registration. You can choose to have your prescriptions mailed to your home or to a Plan medical office pharmacy for you to pick up. Online prescription orders must be paid for in advance, by a credit card; or
2. Call our toll-free pharmacy mail-order line at 888/662-4579, weekdays from 9:00 a.m. to 6:00 p.m. Mail-order prescriptions must be paid for in advance by a credit card; or
3. Fill out and send in your request by using one of our mail-order pharmacy envelopes. You can order a supply by calling our Customer Service Department at 404/261-2590. When you use this method of ordering, you can pay by check or credit card.

Allow at least two weeks for the prescription to be filled and delivered to you by mail. Also keep in mind that some medicines, such as those requiring special handling, drugs administered or requiring observation by medical professionals, high cost drugs, drugs requiring refrigeration and controlled medications, are not available through mail-order.

We pay a higher level of benefits when you use a Plan medical office pharmacy.

- **We use a formulary.** We use a formulary, which is a listing of preferred pharmaceutical substances and formulas that our physicians and pharmacists consider to be the most safe, useful and cost-effective ones available. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. Coverage for prescription drugs is limited to those drugs that are included on the Kaiser Permanente formulary.

If you request a non-formulary drug – when your physician feels there is an acceptable formulary alternative – you will be responsible for the full cost of that drug.

However, if your Plan physician believes that a non-formulary drug best treats your medical condition; a formulary drug has been ineffective in the treatment of your medical condition; or a formulary drug causes or is reasonably expected to cause a harmful reaction, then an exception process is available to your Plan physician. In that case, your standard prescription drug copayment would apply. This formulary exception process does not apply to your dentist. In order to be covered at your prescription drug copayment all prescriptions written by your dentist must be included on the Kaiser Permanente formulary.

If you would like information about whether a particular drug is included in our drug formulary, or a list of our formulary drugs, please call our Customer Service Department at 404/261-2590.

- **These are the dispensing limitations.** Up to the lesser of a 30 day supply or the standard prescription amount of prescribed covered drugs and certain supplies. For example, the standard prescription amount for migraine medications, ophthalmic, otic and topical medications, and for oral and nasal inhalers, is the smallest standard package size available. Drugs to treat sexual dysfunction have dispensing limitations. Contact us for details. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call a Kaiser Permanente medical center pharmacy. If members need assistance in contacting a Kaiser Permanente medical center pharmacy, they should call our Customer Service Department at 404/261-2590.
- **Why use generic drugs?** The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your Plan less money than a name-brand drug, and are a safe and economic way to meet your prescription drug needs. Unless otherwise specified by your Plan physician or dentist, generic drugs may be used to fill a prescription.
- **When you do 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.
- **If you have questions** about your prescription drug benefits, please contact our Customer Service Department at 404/261-2590 (locally), 888/865-5813 (long distance) or 800/255-0056 (TTY number).

Benefit Description	You pay	
Covered medications and supplies	High Option	Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Diabetic supplies limited to glucose test strips, test tape and tablets, and acetone test tablets • Disposable needles and syringes for the administration of covered medications • Inhalers • Compounded dermatological preparations prepared by a pharmacist • Oral contraceptive drugs • Diaphragms • Growth hormone therapy (GHT) in limited circumstances for treatment of children with Turner’s syndrome or classical growth hormone deficiency, only with prior approval by Plan physicians • Amino acid-modified products used to treat congenital errors of amino acid metabolism 	<p>\$10 per prescription or refill for covered generic drugs obtained at a Plan medical office pharmacy</p> <p>\$16 per prescription or refill for covered generic drugs obtained at a Plan participating community pharmacy</p> <p>\$25 per prescription or refill for covered brand name drugs obtained at a Plan medical office pharmacy</p> <p>\$31 per prescription or refill for covered brand name drugs obtained at a Plan participating community pharmacy copay</p>	<p>\$20 per prescription or refill for covered generic drugs obtained at a Plan medical office pharmacy</p> <p>\$26 per prescription or refill for covered generic drugs obtained at a Plan participating community pharmacy</p> <p>\$30 per prescription or refill for covered brand name drugs obtained at a Plan medical office pharmacy</p> <p>\$36 per prescription or refill for covered brand name drugs obtained at a Plan participating community pharmacy</p>

Covered medications and supplies - continued on next page

High and Standard Option Option

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Post-surgical immunosuppressant outpatient drugs required as a result of a covered transplant 	<p>\$10 per prescription or refill for covered generic drugs obtained at a Plan medical office pharmacy</p> <p>\$16 per prescription or refill for covered generic drugs obtained at a Plan participating community pharmacy</p> <p>\$25 per prescription or refill for covered brand name drugs obtained at a Plan medical office pharmacy</p> <p>\$31 per prescription or refill for covered brand name drugs obtained at a Plan participating community pharmacy copay</p>	<p>\$20 per prescription or refill for covered generic drugs obtained at a Plan medical office pharmacy</p> <p>\$26 per prescription or refill for covered generic drugs obtained at a Plan participating community pharmacy</p> <p>\$30 per prescription or refill for covered brand name drugs obtained at a Plan medical office pharmacy</p> <p>\$36 per prescription or refill for covered brand name drugs obtained at a Plan participating community pharmacy</p>
<ul style="list-style-type: none"> Intravenous fluids and intravenous medications for home use 	Nothing	Nothing (No pharmacy deductible)
<ul style="list-style-type: none"> Implanted time release drugs, including contraceptive drugs Injectable contraceptive drugs Topical contraceptives <p>Note: We do not refund any portion of your copayment if you request removal of the implanted drug time-release medication before the end of its expected life.</p>	The generic or brand name prescription drug copayment multiplied by the number of months the drug is expected to be effective, not to exceed \$200	The generic or brand name prescription drug copayment multiplied by the number of months the drug is expected to be effective, not to exceed \$200
<ul style="list-style-type: none"> Intrauterine devices 	\$50 per device	\$50 per device
<ul style="list-style-type: none"> Drugs for covered infertility treatments Drugs for sexual dysfunction <p>Note: Drugs to treat sexual dysfunction have dispensing limitations. Contact us for details.</p>	50% of our allowance	50% of our allowance (No pharmacy deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Drugs and supplies for cosmetic purposes</i> <i>Drugs to enhance athletic performance</i> <i>Spacer devices</i> <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> <i>Vitamins, nutrients and food supplements that can be purchased without a prescription</i> <i>Nonprescription medicines</i> <i>Prescription drugs for which there is a nonprescription equivalent available</i> 	<i>All charges</i>	<i>All charges</i>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Any packaging other than the dispensing pharmacy's standard packaging</i> • <i>Drugs related to non-covered infertility services</i> • <i>Contraceptive devices, except diaphragms and intrauterine devices</i> • <i>Smoking cessation drugs and medications, including nicotine patches</i> • <i>Drugs for non-covered services</i> • <i>Replacement of lost, stolen or damaged drugs and accessories</i> • <i>Infant formulas, except for amino acid-modified products noted above</i> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available, except those listed on the Plan's formulary and prescribed by a Plan physician</i> • <i>Drugs that shorten the duration of the common cold</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care for services listed under “Other dental benefits”. Call Customer Service for a list of participating dentists.
- Under Standard Option - The calendar year deductible is \$500 per person (\$1,500 per family). The calendar year deductible and Plan coinsurance apply to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Under High Option –We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
	High Option	Standard Option
Accidental injury benefit		
<p>We cover services to promptly repair (but not replace) a sound, natural tooth. The need for these services must result from an accidental injury and all services must be completed within 365 days of the injury in order to be covered.</p> <ul style="list-style-type: none"> • damage is due to an accidental injury from trauma to the mouth from violent contact with an external object, • the tooth has not been restored previously, except in a proper manner, and • the tooth has not been weakened by decay, periodontal disease, or other existing dental pathology. 	<p>50% of the first \$1,000 of covered charges (that is, up to \$500) per accident; all charges thereafter</p> <p>The Maximum Benefit Amount we will pay is \$500 per accident.</p>	<p>50% of the first \$1,000 of covered charges (that is, up to \$500) per accident; all charges thereafter</p> <p>(No deductible)</p> <p>The Maximum Benefit Amount we will pay is \$500 per accident.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services for conditions caused by an accidental injury occurring before your eligibility date</i> 	<i>All charges</i>	<i>All charges</i>

Dental benefits

Dental Benefits	You Pay	
Preventive dental	High Option	Standard Option
<p>The following preventive dental services are covered when provided by a Delta Premier dentist or any licensed dentist:</p> <ul style="list-style-type: none"> • Routine oral examinations twice a year • Dental prophylaxis (cleaning) twice a year (excluding periodontal prophylaxis) • Topical application of fluoride twice a year • Bitewing X-ray twice a year for children under age 18 and once a year for adults ages 18 and over • Full mouth series X-rays once every 5 years <p>Note: You may choose to receive preventive dental benefits from either a Delta Premier dentist or any licensed dentist. Keep in mind, your out-of-pocket expenses may be lower if you choose to receive your care from a Delta Premier dentist. Call Customer Service for a listing of Delta Premier dentists.</p>	<p>30% of the dentist's usual and customary fee schedule or the fee actually charged, whichever is less</p>	<p>30% of the dentist's usual and customary fee schedule or the fee actually charged, whichever is less</p> <p>(No deductible)</p>
Other dental benefits	High Option	Standard Option
<p>We cover non-surgical treatment of temporomandibular joint (TMJ) disorder, including splints and appliances</p>	<p>50% of our allowance</p>	<p>50% of our allowance</p> <p>(No deductible)</p>
<p>General anesthesia and associated hospital or ambulatory surgery facility charges in conjunction with dental care are covered for persons:</p> <ul style="list-style-type: none"> • 7 years of age or younger • Who are developmentally disabled • Who are not able to have dental care under local anesthesia due to a neurological or medically compromising condition • Who have sustained extensive facial or dental trauma 	<p>Nothing</p> <p>See Section 5(c) for facility charges.</p>	<p>20% of our allowance after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>
<p>Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease</p>	<p>\$75 per office visit</p>	<p>20% of our allowance after you have met your calendar year deductible</p>
<p><i>Not covered: Other dental services not specifically shown as covered</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5(h). Special features

Feature	Description
24 hour advice line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 404/365-0966 (locally) or 888/865-5813 (long distance) and talk with a registered nurse who can help assess medical symptoms and provide advice over the phone, when medically appropriate.
Centers of Excellence	<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 nationally contracted network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.</p>
Flexible benefits option	<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. • We review alternative treatments on an ongoing basis. • 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.
Services for the deaf, hard of hearing or speech impaired	We provide a TTY/text telephone number at: 800/255-0056. Sign language services are also available.
Services from other Kaiser Permanente or allied plans	<p>When you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered services, copayments and coinsurance described in this FEHB brochure.</p> <p>The 90-day limit on visiting member care does not apply to a dependent child who attends an accredited college or accredited vocational school.</p> <p>Please call our Customer Service Department at 404/261-2590 or 888/865-5813 to receive more information about visiting member care, including facility locations in other service areas. Service areas and facilities where you may obtain visiting member care may change at any time.</p>
Smoking cessation	<p>Kaiser Permanente offers smoking cessation classes as described under Educational classes and programs in Section 5(a). In addition to the classes we also offer the following:</p> <ul style="list-style-type: none"> • Kaiser Permanente’s “Great Start” Quit Line is free and available for pregnant women 24 hours a day.

Feature - continued on next page

Feature	Description
Feature (cont.)	
	<ul style="list-style-type: none"> • Free smoking cessation resources are available, including a self-help booklet for pregnant women, as well as brochures for adults and teens. • Bookmark listing of smoking cessation resources • Bi-Annual smoking cessation resource outreach mailings to all identified smokers <p>For more information or to order any of the above materials please call our Customer Service Department at 404/261-2590.</p>
Travel benefit	<p>Kaiser Permanente’s travel benefit for Federal employees provides you with outpatient follow-up and/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 and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency services/accident benefit and include:</p> <ul style="list-style-type: none"> • 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. <p>You pay \$25 for each follow-up or continuing care office visit. This amount will be deducted from the reimbursement we make to you or to the provider. We limit our payment for this travel benefit to no more than \$1,200 each calendar year. For more information about this benefit call our Customer Service Department at 404/261-2590. Our TTY is 800/255-0056. File claims as shown in Section 7.</p> <p><i>The following are a few examples of services not included in your travel benefits coverage:</i></p> <ul style="list-style-type: none"> • <i>Non-emergency hospitalization</i> • <i>Infertility treatments</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> • <i>Transplants</i> • <i>Durable medical equipment (DME)</i> • <i>Prescription drugs</i> • <i>Home health services</i>

Section 5. High Deductible Health Plan Benefits

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Section 5. High Deductible Health Plan Benefits Overview

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

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. Also read the General exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 404/261-2590 or at our Web site at <http://kp.org/feds>.

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

When you enroll in this HDHP, based on eligibility, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total Health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With this Plan, preventive care is covered in full after you pay a copayment, if applicable. As you receive other non-preventive medical care, you must meet the Plan’s deductible before we pay benefits according to the benefits described on page 71. You can choose to use funds available in your HSA or HRA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

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

- **Preventive care** The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), well-child care, child and adult immunizations. Most services are covered at 100% and the services are described in Section 5 *Preventive care*. You may have to pay a copayment for certain preventive care services. *You do not have to meet the deductible before using these services.*

- **Traditional medical coverage** After you have paid the Plan’s deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan pays 80% for covered services from a Plan provider.

Covered services include:

 - Medical services and supplies provided by physicians and other health care professionals
 - Surgical and anesthesia services provided by physicians and other health care professionals
 - Hospital services; other facility or ambulance services
 - Emergency services/accidents
 - Mental health and substance abuse benefits
 - Prescription drug benefits

- **Savings** Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 61 for more details).

• **Health Savings Accounts (HSA)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else’s tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2008, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$45.83 per month for a Self Only enrollment or \$91.67 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$2,900 for an individual and \$5,800 for a family. See maximum contribution information on page 64. You can use funds in your HSA to help pay for services covered under your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

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

HSA features include:

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

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you. Enrollment in the limited expense LEX HCFSA does not affect your eligibility for an HSA or for continued HDHP contributions to your HSA.

• **Health Reimbursement Arrangements (HRA)**

If you aren’t eligible for an HSA, for example you are enrolled in Medicare or are covered by another health plan that is not a high deductible health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2008, we will give you an HRA credit of \$45.83 per month for a Self Only enrollment and \$91.67 per month for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don’t count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by SHPS

- Entire HRA funds (prorated from your effective date to the end of the plan year) are available from your effective date of enrollment
- Tax-free funds can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused funds carryover from year to year
- HRA funds do not earn interest
- HRA funds are forfeited if you leave Federal employment or switch health insurance plans
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements. See *Who is eligible to enroll?* in Section 12 under The Federal Flexible Spending Account Program – *FSAFEDS*.

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

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles coinsurance and copayments) for covered services is limited to \$3,000 for Self Only enrollment or \$6,000 for family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

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

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

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
		Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with Wells Fargo, this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	SHPS is the HRA fiduciary for this Plan.
Account set-up fees	None	None
Account maintenance fee	None	None
Monthly service charge	None	None
Paper statement charge	None	None
Excess contribution adjustment charge	None	Not Applicable
Tax statement copy charge	None	None
Payment card for new accounts charge	None - Two payment cards issued per new account	None - One payment card issued per new account
Debit card reorder/ replacement charge	\$10.00 per card	\$12.00 per card
Debit card additional card order charge	\$10.00 per additional card	\$5.00 per additional card
Debit card transactions charge	None	None
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • Enroll in this HDHP • Have no other health insurance coverage that is not a high deductible health plan (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not able to be claimed as a dependent on someone else’s tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork. 	<p>You must enroll in this HDHP.</p> <p>Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.</p>

Funding

If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.

Eligibility for the annual funds will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.

In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).

• **Self Only enrollment**

For 2008, a monthly premium pass through of \$45.83 will be made by the HDHP directly into your HSA each month.

For 2008, your HRA annual fund is \$550 (prorated for mid-year enrollment).

• **Self and Family enrollment**

For 2008, a monthly premium pass through of \$91.67 will be made by the HDHP directly into your HSA each month.

For 2008, your HRA annual fund is \$1,100 (prorated for mid-year enrollment).

Contributions/credits

The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount of \$2,900 for Self Only or \$5,800 for Self and Family.

The full HRA fund will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.

You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.

If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP).

HSAs earn tax-free interest (does not affect your annual maximum contribution).

Catch-up contribution discussed on page 67.

• Self Only enrollment

You may make an annual maximum contribution of \$2,900.

You cannot contribute to the HRA.

• Self and Family enrollment

You may make an annual maximum contribution of \$5,800.

You cannot contribute to the HRA.

Access funds

You can access your HSA by the following methods:

- CarePay HSA Visa Debit card
- Reimbursement form via fax or mail

For qualified medical expenses under your HDHP, you will be automatically reimbursed when you use your HRA payment card. If you use cash, check or another payment card, you must submit a reimbursement form to access your HRA funds.

• Distributions/withdrawals

You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.

You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.

• Medical

See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.

See *Availability of funds* below for information on when funds are available in the HRA.

See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.

• Non-medical

If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.

Not applicable – distributions will not be made for anything other than non-covered qualified medical expenses.

When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax, except for qualified medical expenses.

Availability of funds

Funds are not available for withdrawal until all the following steps are completed:

The entire amount of your HRA will be available to you upon your enrollment in the HDHP.

- Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change).
- The Plan receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA.
- The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.

Account owner

FEHB enrollee

HDHP

Portable

You can take this account with you when you change plans, separate or retire.

If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 63 for HSA eligibility.

If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.

If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.

Annual rollover

Yes, accumulates without a maximum cap.

Yes, accumulates without a maximum cap.

If you have an HSA

If you have an HSA

- **Contributions**

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

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

- **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. In 2008, you may contribute up to \$900 in catch-up contributions. The allowable catch-up contribution will be \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.

- **If you die**

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

- **Qualified expenses**

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

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

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at www.irs.gov and click on “Forms and Publications.” Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

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

- **Minimum reimbursements from your HSA**

You can request reimbursement in any amount.

If you have an HRA

If you have an HRA

- **Why an HRA is established**

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

- **How an HRA differs**

Please review the chart on page 63, which details the differences between an HRA and an HSA. The major differences are:

- You cannot make contributions to an HRA
- Funds are forfeited if you leave the HDHP
- An HRA does not earn interest, and
- HRAs can only pay for qualified medical expenses for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible. You only owe your copayment and coinsurance for certain covered preventive care services.
- You must use providers that are part of our network.
- For all other covered expenses, please see HDHP Section 5 – *Traditional medical coverage subject to the deductible.*

Benefit Description	You pay
Preventive care, adult	
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 40 and older • Routine well-woman exam including Pap test, one visit every 12 months from last date of service • Routine mammogram — covered for women age 35 and older, as follows: <ul style="list-style-type: none"> - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) 	Nothing (Office visit copayment may apply)
<ul style="list-style-type: none"> • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test yearly starting at age 50, - Sigmoidoscopy screening – every five years starting at age 50. 	Nothing
<ul style="list-style-type: none"> • Routine physicals: <ul style="list-style-type: none"> - One exam every 12 months • Routine exams limited to: <ul style="list-style-type: none"> - One routine eye exam every 12 months - One routine OB/GYN exam every 12 months including one Pap smear and related services 	\$15 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<i>All charges</i>

Benefit Description	You pay
Preventive care, children	
Professional services, such as: <ul style="list-style-type: none"> • Well-child visits for routine examinations, immunizations and care (up to age 2) • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing
Examinations, such as: <ul style="list-style-type: none"> • Eye exam through age 17 to determine the need for vision correction • Hearing exams through age 17 to determine the need for hearing correction • Examinations done on the day of immunization • Well-child visits for routine examinations, age 2 and over 	\$15 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment, insurance or licensing; participating in employee programs; attending schools or camp; travel; or court order required for parole or probation.</i> • <i>Immunizations, boosters, and medications for travel.</i> 	<i>All charges</i>
Dental preventive care	
The following preventive dental services are covered when provided by a Delta Premier dentist or any licensed dentist: <ul style="list-style-type: none"> • Routine oral examinations twice a year • Dental prophylaxis (cleaning) twice a year (excluding periodontal prophylaxis) • Topical application of fluoride twice a year • Bitewing x-rays twice a year for children under age 18 and once a year for adults age 18 and over • Full mouth series X-rays once every five years <p>Note: You may choose to receive preventive dental benefits from either a Delta Premier dentist or any licensed dentist. Keep in mind, your out-of-pocket expenses may be lower if you choose to receive your care from a Delta Premier dentist. Call Customer Service for a listing of Delta Premier dentists.</p>	30% of the dentist’s usual and customary fee schedule or the fee actually charged, whichever is less

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% (an office visit copayment may apply) (see page 69) and is not subject to the calendar year deductible.
- The deductible is \$1,100 for Self Only enrollment or \$2,200 for family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance for covered expenses.
- When you use Plan providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance and deductibles total \$3,000 for Self Only enrollment or \$6,000 for family enrollment in any calendar year, you do not have to pay any more for covered services from Plan providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	
The deductible applies to all benefits in this Section. In the You pay column, we say “No deductible” when it does not apply. When you receive covered services from Plan providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$1,100 for Self Only enrollment or \$2,200 for family enrollment
After you meet the deductible, we pay the allowable charge (less your coinsurance) until you meet the annual catastrophic out-of-pocket maximum.	After you meet the deductible, you pay the indicated coinsurance for covered services. You may choose to pay the deductible and coinsurance from your HSA or HRA, or you can pay for them out-of-pocket.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR SOME MEDICAL PROCEDURES:** Please refer to the preauthorization list shown in Section 3 to be sure which services and supplies require preauthorization.

Benefit Description	You pay After the calendar year deductible...
Diagnostic and treatment services	
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • Second surgical opinions • In an urgent care center • During a hospital stay • In a skilled nursing facility • At home Certain procedures received during an office visit, such as: <ul style="list-style-type: none"> • Cardiac stress tests • Nerve conduction studies 	20% of our allowance
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CT Scans/MRI PET scans, nuclear medicine 	20% of our allowance

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

Benefit Description	You pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests (cont.)	
<ul style="list-style-type: none"> • Ultrasound • Barium enema • Electrocardiogram and EEG 	20% of our allowance
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <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. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay surgeon services (delivery) and hospitalization the same as for illness and injury. See Surgery benefits (HDHP Section 5(b)) and Hospital benefits (HDHP Section 5(c)) 	20% of our allowance
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges</i>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures HDHP Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover surgically implanted contraceptives, diaphragms, injectable contraceptive drugs, intrauterine devices (IUDs) and oral contraceptives under the prescription drug benefit. See HDHP Section 5 (f)</p>	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling.</i> 	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...
Infertility services	
<p>Diagnosis of infertility such as:</p> <ul style="list-style-type: none"> • Visits for diagnosis of involuntary infertility • Diagnostic imaging and laboratory tests, limited to: hysterosalpingogram (HSG), post-coital test, fasting blood glucose, fasting insulin, semen analysis, tests to rule out sexually transmitted diseases and hormone level tests. <p>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) 	<p>20% of our allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Fertility drugs</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Semen or eggs, and services and supplies related to their procurement and storage.</i> <p><i>Notes:</i></p> <ul style="list-style-type: none"> • <i>These exclusions apply to fertile as well as infertile individuals or couples.</i> • <i>Infertility services are not available when either member of the family has been voluntarily surgically sterilized.</i> 	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>20% of our allowance</p>
<ul style="list-style-type: none"> • Allergy serum 	<p>Nothing</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants in HDHP Section 5(b).</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit and requires preauthorization. See <i>Services requiring our preauthorization</i> in Section 3.</p>	20% of our allowance
<p><i>Not covered: Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered.</i></p>	All charges
Physical and occupational therapies	
<ul style="list-style-type: none"> • Up to 20 visits per condition per calendar year for the services of: <ul style="list-style-type: none"> - Qualified physical therapists - Occupational therapists • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 weeks or 36 visits. <p>Notes:</p> <ul style="list-style-type: none"> • We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. • We cover occupational therapy to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life. 	20% of our allowance
<ul style="list-style-type: none"> • Comprehensive outpatient rehabilitation facility services 	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> • <i>Cognitive rehabilitation programs</i> • <i>Vocational rehabilitation programs</i> • <i>Therapies done primarily for educational purposes</i> 	All charges

Benefit Description	You pay After the calendar year deductible...
Speech therapy	
Up to 20 visits per condition per calendar year.	20% of our allowance
<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"> • <i>Therapy for educational placement or other educational purposes</i> • <i>Training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation</i> • <i>Therapy for tongue thrust in the absence of swallowing problems</i> • <i>Voice therapy for occupation or performing arts</i> 	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Hearing testing to determine the need for hearing correction • Audiometric exams 	20% of our allowance
<ul style="list-style-type: none"> • Hearing aids, including testing and examinations for them, for children under age 18 	<p>All charges in excess of \$1,000 allowance per hearing impaired ear every 36 months.</p> <p><i>Note: Amounts in excess of the allowance are not covered and do not count toward the deductible or out of pocket maximum.</i></p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, including testing and examinations for them for all persons age 18 and over</i> 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Diagnosis and treatment of diseases of the eye • Annual eye refractions (to provide written lens prescription) <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Corrective eyeglasses and frames or contact lenses (including the examination and fitting of contact lenses)</i> • <i>Refractions for contact lenses</i> • <i>Eye exercises, orthoptics and visual training</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>An eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism</i> • <i>Low vision aids</i> 	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	20% of our allowance
<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>
Orthopedic and prosthetic devices	
External prosthetic and orthotic devices, such as: <ul style="list-style-type: none"> • Ostomy and urological supplies • Artificial limbs and eyes; stump hose • Braces • Therapeutic shoes required for conditions associated with diabetes • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Scoliosis braces • Lenses following cataract removal • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Internal prosthetic devices , such as artificial joints, pacemakers, intraocular lens following cataract removal, cochlear implants, and surgically implanted breast implant following mastectomy. <p>Note: See HDHP Section 5(b) for coverage of the surgery to insert the device.</p>	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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>Experimental or research equipment</i> 	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...
Durable medical equipment (DME)	
<p>When prescribed by a Plan physician, we cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Infant apnea monitors; • Oxygen-dispensing equipment; • Blood glucose monitors; and • Insulin pumps. <p>Notes:</p> <ul style="list-style-type: none"> • Durable medical equipment (DME) is equipment that is prescribed by a Plan physician and is intended for repeated use, medically necessary, primarily and customarily used to serve a medical purpose, generally useful only to a person who is ill or injured, designed for prolonged use, appropriate for use in the home, and serves a specific therapeutic purpose in the treatment of an illness or injury. • 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>20% of our allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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>Devices for testing blood or other body substances</i> • <i>Electronic monitors of bodily functions, except apnea monitors and blood glucose monitors</i> • <i>Disposable supplies</i> • <i>Replacement of lost equipment</i> • <i>Repair, 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>Spare or alternate use equipment</i> • <i>Experimental or research equipment</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Home health services	
<p>If you are homebound and reside in the service area:</p> <ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), home health aide, physical or occupational therapist, and speech and language pathologist. • Services include oxygen therapy, intravenous therapy and medications. 	20% of our allowance
<p>Notes:</p> <ul style="list-style-type: none"> • Your Plan physician will periodically review the program for continuing appropriateness and need. • These 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. 	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Private duty nursing</i> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>Custodial care</i> • <i>Care that the Plan determines may be appropriately provided in a Plan hospital, medical center, medical office, skilled nursing facility or other facility designated by Health Plan and we provide, or offer to provide, that care in one of these facilities.</i> • <i>Services outside our service area</i> 	<i>All charges</i>
Chiropractic	
No benefit	<i>All charges</i>
Alternative treatments	
No benefit	<i>All charges</i>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self management 	20% of our allowance

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. Consult with your physician to determine what is appropriate for you. Services may be covered provided that established Plan physicians' criteria are met.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in HDHP Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.

Benefit Description	You pay After the calendar year deductible...
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Colonoscopy screening • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) 	20% of our allowance
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery). You must: <ul style="list-style-type: none"> - be 18 years of age or older; and - have a Body Mass Index (BMI) greater than 40; or a BMI greater than 35 with another severe or life threatening condition such as: sleep apnea, cardiomyopathy or severe diabetes; and - have weight control failure; and 	20% of our allowance

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	
<ul style="list-style-type: none"> - have made a commitment to a long term weight management plan and a behavioral health and nutrition assessment; and - have no untreated metabolic cause of obesity <p>Notes:</p> <ul style="list-style-type: none"> • You will need to meet the above qualifications before your Plan provider will refer you to our bariatric surgery program. This program may refer you to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including: <ul style="list-style-type: none"> - nutritional, - psychological, - medical; and - social readiness for surgery. • Final approval for surgical treatment will be required from The Southeast Permanente Medical Group’s designated physician. See Section 3, <i>Services requiring our prior approval</i>, for more information. 	<p>20% of our allowance</p>
<ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See HDHP Section 5(a), <i>Orthopedic and prosthetic devices</i>, for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Surgically implanted time-release contraceptives and other drugs and insertion of intrauterine devices (IUDs). • Treatment of burns <p>Notes:</p> <ul style="list-style-type: none"> • We cover the cost of these surgically implanted time-release contraceptive drugs and intrauterine devices under the prescription drug benefit (see HDHP Section 5(f)). • Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. 	<p>20% of our allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Cosmetic surgery</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Reconstructive surgery	
<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"> - the condition produced a major effect on the member’s appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • Surgery for treatment of a form of congenital hemangioma known as port wine stains on the face of members 18 years or younger • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery on the unaffected breast to produce a symmetrical appearance; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <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% of our allowance</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 through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<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; 	<p>20% of our allowance</p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...
Oral and maxillofacial surgery (cont.)	
<ul style="list-style-type: none"> • Medical and surgical treatment of temporomandibular joint (TMJ) disorder (non-dental); and • Other surgical procedures that do not involve the teeth or their supporting structures. 	20% of our allowance
<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)</i> • <i>Shortening of the mandible or maxillae for cosmetic purposes</i> • <i>Correction of any malocclusion not listed above</i> • <i>Dental services associated with medical treatment such as surgery, except for services related to accidental injury of teeth (See Section 5(g))</i> 	<i>All charges</i>
Organ/tissue transplants	
<p>Solid organ tissue transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Intestinal transplants (small intestine) <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas 	20% of our allowance
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: The medical necessity is considered satisfied if the patient meets the diagnosis and staging description.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia 	20% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	20% of our allowance
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogenic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors 	20% of our allowance
<p>Limited Benefits – Autologous blood or bone marrow stem cell transplants for breast cancer and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-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>Notes:</p> <ul style="list-style-type: none"> • We cover related medical and hospital expenses of the donor when we cover the recipient. • Please refer to Section 5(h). Special features for information on our Centers of Excellence. 	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of non-human or artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...
Anesthesia	
Professional services provided in – <ul style="list-style-type: none">• Hospital (inpatient)• Hospital outpatient department• Skilled nursing facility• Ambulatory surgical center• Office	20% of our allowance

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions , limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary .
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your cost for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in HDHP Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	
Room and board, such as: <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood and blood products • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services 	20% of our allowance

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	
<p>Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The need for anesthesia, by itself, is not such a condition.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care and care in an intermediate care facility</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, and guest meals and beds</i> • <i>Private nursing care, except when medically necessary</i> • <i>Inpatient dental procedures</i> • <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient</i> 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Lab, X-ray, and other diagnostic tests • Blood and blood products • Pre-surgical testing • Dressings, casts, and sterile trays • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>20% of our allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient.</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay After the calendar year deductible...
Skilled nursing care facility benefits	
<p>Up to 100 days per calendar year when you need full-time nursing care.</p> <p>All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Room and board • General nursing care • Medical social services • Prescribed drugs, biologicals, supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility 	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care and care in an intermediate care facility</i> • <i>Personal comfort items, such as telephone, television, barber services, and guest meals and beds</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 the home, when a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home <p>Services include inpatient care under limited circumstances, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less.</p>	20% of our allowance

Hospice care - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Hospice care (cont.)	
<p>Note: Hospice is a program for caring for the terminally ill patient that emphasizes supportive services, such as home care and pain and symptom control, rather than curative care. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, therapy services for purposes of safety and symptom control, physician services, palliative drugs in accord with our drug formulary guidelines, durable medical equipment (DME), and short-term inpatient care for pain control and acute and chronic symptom management. We also provide inpatient respite care, counseling and bereavement services. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing (private duty nursing)</i> • <i>Homemaker services</i> 	<p><i>All charges</i></p>
Ambulance	
<ul style="list-style-type: none"> • Local licensed ambulance service when medically necessary <p>Notes: See HDHP Section 5(d) for emergency services</p>	<p>20% of our allowance per trip</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider.</i> 	<p><i>All charges</i></p>

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

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

Emergencies within our service area:

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

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

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

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

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 on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan physician believes care can be better provided in a Plan hospital, then we will transfer you when medically feasible, with any ambulance charges covered in full.

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 Customer Service Department in the Atlanta area at 404/261-2590, or from other areas at 888/865-5813.

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	
<ul style="list-style-type: none"> Emergency care at an urgent care center not designated by the Plan Emergency care as an outpatient at a hospital, including physicians' services 	20% of our allowance
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	
<ul style="list-style-type: none"> Emergency care at an urgent care center not designated by the Plan Emergency care as an outpatient in a hospital, including physicians' services 	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</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>
Ambulance	
<p>Licensed ambulance service when medically necessary.</p> <p>Notes:</p> <ul style="list-style-type: none"> See HDHP Section 5(c) for non-emergency service. Trip means anytime an ambulance is summoned on your behalf. 	20% of our allowance per trip
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Trips we determine are not medically necessary</i> <i>Transportation by car, taxi, bus, gurney van, wheel chair van, minivan and any other type of transportation, even if it is the only way to travel to a provider or facility</i> 	<i>All charges</i>

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.

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR INPATIENT SERVICES.**

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits	
<p>We cover all diagnostic and treatment services recommended by a Plan mental health or substance abuse provider and contained in a treatment plan that we approve. 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 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 mental health or substance abuse 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 plan in favor of another. 	20% of our allowance
<p>Diagnosis and treatment of psychiatric conditions, mental illness, or disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnostic tests • Crisis intervention and stabilization for acute episodes • Treatment and counseling (including group and individual therapy visits) 	20% of our allowance

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	
<ul style="list-style-type: none"> Medication evaluation and management 	20% of our allowance
<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) Rehabilitative care Psychological testing to determine the appropriate psychiatric treatment <p>Notes:</p> <ul style="list-style-type: none"> You may see a Plan mental health or substance abuse provider for these services without a referral from your primary care physician. See Section 3, <i>How you get care</i>, for information about services requiring our prior approval. Your Plan mental health or substance abuse provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you. 	20% of our allowance
<ul style="list-style-type: none"> Inpatient psychiatric or substance abuse care Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment All inpatient admissions and hospital alternative services treatment programs require approval by a Plan mental health or substance abuse physician. 	20% of our allowance
<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 disorders 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>All charges</i>

Mental health and substance abuse benefits - continued on next page

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 96.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- Your physician must get preauthorization for certain drugs. Certain prescription drugs require approval prior to dispensing. The list of prescription drugs that require preauthorization is subject to periodic review and modification. If you would like to know if a drug requires preauthorization you may contact our Customer Service Department at 404/261-2590.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription?** A Plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan medical office pharmacy or a Plan participating community pharmacy.

It may be possible for you to receive certain refills by mail at no extra charge. You can order prescription refills for mail delivery three ways:

1. Online, using our Members Only Web site at <http://kp.org/feds>. This site requires online registration. You can choose to have your prescriptions mailed to your home or to a Plan medical office pharmacy for you to pick up. Online prescription orders must be paid for in advance, by a credit card; or
2. Call our toll-free pharmacy mail-order line at 888/662-4579, weekdays from 9:00 a.m. to 6:00 p.m. Mail-order prescriptions must be paid for in advance by a credit card; or
3. Fill out and send in your request by using one of our mail-order pharmacy envelopes. You can order a supply by calling our Customer Service Department at 404/261-2590. When you use this method of ordering, you can pay by check or credit card.

Allow at least two weeks for the prescription to be filled and delivered to you by mail. Also keep in mind that some medicines, such as those requiring special handling, drugs administered or requiring observation by medical professionals, high cost drugs, drugs requiring refrigeration and controlled medications, are not available through mail-order.

We pay a higher level of benefits when you use a Plan medical office pharmacy.

- **We use a formulary.** We use a formulary, which is a listing of preferred pharmaceutical substances and formulas that our physicians and pharmacists consider to be the most safe, useful and cost-effective ones available. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. Coverage for prescription drugs is limited to those drugs that are included on the Kaiser Permanente formulary.

If you request a non-formulary drug – when your physician feels there is an acceptable formulary alternative – you will be responsible for the full cost of that drug.

However, if your Plan physician believes that a non-formulary drug best treats your medical condition; a formulary drug has been ineffective in the treatment of your medical condition; or a formulary drug causes or is reasonably expected to cause a harmful reaction, then an exception process is available to your Plan physician. In that case, your standard prescription drug copayment would apply. This formulary exception process does not apply to your dentist. In order to be covered at your prescription drug copayment all prescriptions written by your dentist must be included on the Kaiser Permanente formulary.

If you would like information about whether a particular drug is included in our drug formulary, or a list of our formulary drugs, please call our Customer Service Department at 404/261-2590.

- **These are the dispensing limitations.** Up to the lesser of a 30 day supply or the standard prescription amount of prescribed covered drugs and certain supplies. For example, the standard prescription amount for migraine medications, ophthalmic, otic and topical medications, and for oral and nasal inhalers, is the smallest standard package size available. Drugs to treat sexual dysfunction have dispensing limitations. Contact us for details. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call a Kaiser Permanente medical center pharmacy. If members need assistance in contacting a Kaiser Permanente medical center pharmacy, they should call our Customer Service Department at 404/261-2590.
- **Why use generic drugs?** The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your Plan less money than a name-brand drug, and are a safe and economic way to meet your prescription drug needs. Unless otherwise specified by your Plan physician or dentist, generic drugs may be used to fill a prescription.
- **When you do 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.
- **If you have questions** about your prescription drug benefits, please contact our Customer Service Department at 404/261-2590 (locally), 888/865-5813 (long distance) or 800/255-0056 (TTY number).

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Diabetic supplies limited to glucose test strips, sugar test tape, sugar tablets and acetone test tablets • Disposable needles and syringes for the administration of covered medications • Inhalers • Compounded dermatological preparations prepared by a pharmacist • Oral contraceptive drugs 	20% of our allowance

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	
<ul style="list-style-type: none"> • Diaphragms • Growth hormone therapy (GHT) in limited circumstances for treatment of children with Turner’s syndrome or classical growth hormone deficiency, only with prior approval by Plan physicians • Amino acid-modified products used to treat congenital errors of amino acid metabolism • Post-surgical immunosuppressant outpatient drugs required as a result of a covered transplant • Intravenous fluids and intravenous medications for home use • Injectable contraceptive drugs • Topical contraceptives • Implanted time release drugs, including contraceptive drugs • Intrauterine devices • Drugs for sexual dysfunction <p>Notes:</p> <ul style="list-style-type: none"> • We do not refund any portion of your copayment if you request removal of the implanted drug time-release medication or device before the end of its expected life. • Drugs to treat sexual dysfunction have dispensing limitations. Contact us for details. 	<p>20% of our allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Spacer devices</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements that can be purchased without a prescription</i> • <i>Nonprescription medicines</i> • <i>Prescription drugs for which there is a nonprescription equivalent available</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Any packaging other than the dispensing pharmacy’s standard packaging</i> • <i>Contraceptive devices, except diaphragms and intrauterine devices</i> • <i>Smoking cessation drugs and medications, including nicotine patches</i> • <i>Drugs for non-covered services</i> • <i>Replacement of lost, stolen or damaged drugs and accessories</i> 	<p><i>All charges</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	
<ul style="list-style-type: none"> • <i>Infant formulas, except for amino acid-modified products noted above</i> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available, except those listed on the Plan’s formulary and prescribed by a Plan physician</i> • <i>Drugs that shorten the duration of the common cold</i> 	<i>All charges</i>

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care for services listed under “Other dental benefits”. Call Customer Service for a list of participating dentists.
- The deductible is \$1,100 for Self Only enrollment and \$2,200 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See HDHP 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 cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Accidental injury, and other dental benefits	
<p>We cover services to promptly repair (but not replace) a sound, natural tooth. The need for these services must result from an accidental injury and all services must be completed within 365 days of the injury in order to be covered.</p> <ul style="list-style-type: none"> • damage is due to an accidental injury from trauma to the mouth from violent contact with an external object • the tooth has not been restored previously, except in a proper manner, and • the tooth has not been weakened by decay, periodontal disease, or other existing dental pathology. 	<p>20% of our allowance after you have met your calendar year deductible</p> <p>The Maximum Benefit Amount we will pay is \$500 per accident.</p>
<p><i>Not covered: Services for conditions caused by an accidental injury occurring before your eligibility date</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Dental benefits	
<ul style="list-style-type: none"> • Non-surgical treatment of temporomandibular joint dysfunction (TMJ), including splints and appliances. • General anesthesia and associated hospital or ambulatory surgery facility charges in conjunction with dental care are covered for persons: <ul style="list-style-type: none"> - 7 years of age or younger - Who are developmentally disabled - Who are not able to have dental care under local anesthesia due to a neurological or medically compromising condition - Who have sustained extensive facial or dental trauma • Extraction of teeth to prepare jaw for radiation treatment of neoplastic disease 	<p>20% of our allowance after you have met your calendar year deductible</p>
<p><i>Not covered: Other dental services not specifically shown as covered</i></p>	<p><i>All charges</i></p>

Section 5(h). Special features

Feature	Description
24 hour advice line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 404/365-0966 (locally) or 888/865-5813 (long distance) and talk with a registered nurse who can help assess medical symptoms and provide advice over the phone, when medically appropriate.
Centers of Excellence	<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 nationally contracted network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.</p>
Flexible benefits option	<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. • We review alternative treatments on an ongoing basis. • 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.
Services for the deaf, hard of hearing or speech impaired	We provide a TTY/text telephone number at: 800/255-0056. Sign language services are also available.
Smoking cessation	<p>Kaiser Permanente offers smoking cessation classes as described under Educational classes and programs in Section 5(a). In addition to the classes we also offer the following:</p> <ul style="list-style-type: none"> • Kaiser Permanente’s “Great Start” Quit Line is free and available for pregnant women 24 hours a day. • Free smoking cessation resources are available, including a self-help booklet for pregnant women, as well as brochures for adults and teens. • Bookmark listing of smoking cessation resources • Bi-Annual smoking cessation resource outreach mailings to all identified smokers <p>For more information or to order any of the above materials please call our Customer Service Department at 404/261-2590.</p>
Travel benefit	Kaiser Permanente’s travel benefit for Federal employees provides you with outpatient follow-up and/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 and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency services/accident benefit and include:

- Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast.
- Outpatient continuing care for covered services for conditions diagnosed and treated within the previous 90 days by a Kaiser Permanente health care provider or affiliated Plan provider. Services include dialysis and prescription drug monitoring.

You pay 20% of our allowance after you have met your calendar year deductible for each follow-up or continuing care office visit. We limit our payment for this travel benefit to no more than \$1,200 each calendar year. For more information about this benefit call our Customer Service Department at 404/261-2590. Our TTY is 800/255-0056. File claims as shown in Section 7.

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

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

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

Special features	Description
<p>Health education resources</p>	<p>We publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at http://www.kp.org for information on:</p> <ul style="list-style-type: none"> • General health topics • Links to health care news • Cancer and other specific diseases • Drugs/medication interactions • Kids’ health • Patient safety information • and several helpful Web site links.
<p>Account management tools</p>	<p>If you have an HSA,</p> <ul style="list-style-type: none"> • You will receive a monthly statement outlining your account balance and activity for the month. • You may also access your account on-line at www.wfhbs.com/kaiserpermanente. <p>If you have an HRA,</p> <ul style="list-style-type: none"> • You will receive a statement outlining your account balance and activity for the month; monthly if you provide an email address for communication, every other month if you do not provide an email address. • Your HRA balance will be available online through http://kp.org/feds. • You may also access your account by phone at 404/261-2590 (locally) or 888/865-5813 (long distance)
<p>Consumer choice information</p>	<p>As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.kp.org/medstaffdirectory.</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at http://kp.org/feds.</p>
<p>Care support</p>	<p>Patient safety information is available online at www.kp.org.</p>

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all grievances must follow the Plan's guidelines. For additional information contact the Plan at 404-261-2590.

The DeltaCare Dental Program

We are pleased to offer you and your family dental coverage through the DeltaCare Dental program, administered by PMI Dental Health Plan (PMI). The DeltaCare program provides you and your family with quality dental benefits at an affordable cost. DeltaCare is designed to encourage you and your family to visit the dentist regularly to maintain your dental health. With this voluntary comprehensive plan you will have access to routine services such as fillings, crowns, bridges, and extractions, and discounted specialty care services.

When you enroll, you must select a contract dentist to provide services. The DeltaCare network consists of private practice dental facilities that have been carefully screened for quality. Your selected contract dentist will take care of your dental needs. If you require treatment from a specialist, your contract dentist will handle the referral for you.

Under the DeltaCare program many services are covered at no cost, while others have copayments paid directly to your contract dentist. With the DeltaCare program you have no claim forms to complete, no restrictions on pre-existing conditions (except work in progress) and out-of-area dental emergency coverage (up to \$100 per emergency).

	Monthly Premium*	Semi-Annual direct-pay Premiums**
Self Only	\$10.74	\$ 64.44
Self & Spouse	\$18.43	\$110.58
Self & Child	\$18.55	\$111.30
Self & Two or More	\$26.74	\$160.44

These premiums are effective January 1, 2008, through December 31, 2008.

* The monthly premium is automatically withdrawn from your checking, savings or credit union account.

** The semi-annual premium payment is paid by you directly to PMI.

How To Enroll

Simply complete the enrollment form provided with your enrollment materials and return it as described by your benefits administrator. Be sure to indicate a contract dentist from the list of contract dental facilities. You and your eligible dependents may receive care from the same contract dentist, or if you prefer, you may collectively select up to a maximum of three individual contract dental facilities.

After you have enrolled, you will receive a PMI membership packet including an identification card and an Evidence of Coverage booklet that fully describes the benefits of your dental program. Also included in the packet is the name, address and phone number of your contract dentist. Simply call the dental facility to make an appointment.

If you have questions or need additional information, you may contact PMI Dental Health Plan at (800) 422-4234. PMI's automated phone service is available between 8 a.m. and 1 a.m. (Eastern Time) on weekdays, and 24 hours a day on Saturday and Sunday, or you may speak to a Customer Service representative Monday through Friday between 8 a.m. and 9 p.m. (Eastern Time). If you prefer to use the internet to obtain benefit information, you can access the Delta Dental secured internet Web site at www.deltadentins.com. At the Web site you can view and print your DeltaCare benefits, check your eligibility status, print an identification card, obtain information about your assigned provider or find a provider in your area.

SelfWise Program

As a Kaiser Permanente member, you're automatically enrolled in our *SelfWise* Program. Kaiser Permanente's Discount Program is designed to make it easier and more affordable to access services that can help you achieve a healthy balance of body, mind and spirit. *SelfWise* provides access to a variety of complementary health services at a discounted rate including chiropractic care, acupuncture, acupressure, LASIK and massage therapy. Also included are discounted rates at Weight Watchers and local fitness clubs including participating Bally Total Fitness, Crunch Fitness, Curves, and Gold's Gym. *SelfWise* also offers interactive online healthy lifestyle tools; and much more.

Note: This program is available to Kaiser Permanente members and their families. Discounts and services are provided on a fee-for-service basis, do not replace and cannot be combined with any existing benefit, are not covered benefits, and are neither offered nor guaranteed under the contract with the FEHB Program. Kaiser Permanente assumes no responsibility for the arrangement, nature, quality, or outcome of the services. For more information, call 404/261-2590.

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

The exclusions in this section apply to all benefits. There may be other exclusion and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless 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:

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

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 deductible, 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 CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 404/261-2590.

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

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

Submit your claims to:

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

Deadline for filing your claim

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for 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 preauthorization/prior approval required by Section 3. Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: Kaiser Foundation Health Plan of Georgia, Inc., Attention: Appeals Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include 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> <ul style="list-style-type: none">a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orb) Write to you and maintain our denial - go to step 4; orc) Ask 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.</p> <p>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; or• 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or• 120 days after we asked for additional information. <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; and• Your daytime phone number and the best time to call.

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 preauthorization/prior approval, then call us at 404/261-2590 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/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 has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary 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 received your services from Plan providers, we may bill the primary carrier.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You may enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage Plan, Kaiser Permanente Senior Advantage, at no additional cost to our members eligible for Medicare benefits. Our Senior Advantage Plan also includes additional benefits at no cost to the FEHB member. Please review the information on coordinating benefits with Medicare Advantage plans on page 111.
- Part D (Medicare Prescription Drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

Please refer to the Senior Advantage Evidence of Coverage for the complete details of your additional benefits with Kaiser Permanente’s Senior Advantage 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 are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

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

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

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. We will not waive any of our copayments.

If a physician does not participate in Medicare, you will have to file a claim with Medicare. This does not apply if you receive your care from Kaiser Permanente providers.

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

When we are the primary 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. To find out if you need to do something to file your claim, call us at 404/233-3700 (locally), 800/232-4404 (long distance) and 800/255-0056 (TTY line) or see our Web site at <http://kp.org/feds>.

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

- **Medicare Advantage (Part C)**

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

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

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage Plan, Kaiser Permanente Senior Advantage, and also remain enrolled in our FEHB Plan. There is no additional premium to enroll in Senior Advantage.

If you choose to enroll in Kaiser Permanente Senior Advantage some of your benefits may be enhanced and some of your cost sharing arrangements may be lower than those listed in this brochure. We advise you to look at your Senior Advantage EOC for benefit or cost sharing improvements. For a complete description of the Medicare benefits available to you please contact us weekdays, 8:30 a.m. to 5:00 p.m., 404/233-3700 (locally), 800/232-4404 (long distance) and 800/255-0056 (TTY line).

You must use Kaiser Permanente Plan and affiliated providers and continue to pay Medicare premium.

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

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

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

When we are the primary payer, we process the claim first. If you enroll in a Medicare Part D PDP and we are the secondary payer, our Plan owned and operated pharmacies will not consider the PDP benefits. These Plan pharmacies will only provide your FEHB Kaiser benefits.

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

If you enroll in our Kaiser Permanente Senior Advantage plan, you will get all of the benefits of Medicare Part D plus additional benefits, because Medicare Part D is included in our plan.

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 TRICARE or CHAMPVA.

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.

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.

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

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

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. You may also be responsible for additional amounts. See page 16.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	(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 whom, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Custodial care that lasts 90 days or more is sometimes known as long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.
Experimental or investigational service	<p>We do not cover a service, supply, item or drug that we consider experimental. We consider a service, supply, item or drug to be experimental when the service, supply, item or drug:</p> <ul style="list-style-type: none">(1) has not been approved by the FDA; or(2) is the subject of a new drug or new device application on file with the FDA; or(3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or(4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or(5) is subject to the approval or review of an Institutional Review Board; or(6) requires an informed consent that describes the service as experimental or investigational; <p>We carefully evaluate whether a particular therapy is safe and effective or offers a reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental literature.</p>
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, it is either the amount we have negotiated with the non-Plan provider, or if we do not have a negotiated amount, the amount that we believe is usual and customary for the service or supply, compared to the billed charges. Our allowance is based upon the reasonableness of the billed 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.

Us/We

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

You

You refers to the enrollee and each covered family member.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.
Catastrophic limit	The catastrophic limit is the annual amount you pay for deductibles, copayments and Plan allowance. See page 16 for the specific amounts.
Health Reimbursement Arrangement (HRA)	If you are not eligible for an HSA, we will administer and provide an HRA instead for you. An HRA lets you accumulate savings to help pay your health plan deductible and/or for certain expenses that do not count toward the deductible. See page 61 for more detailed information.
Health Savings Account (HSA)	A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary.
Premium contribution to HSA/HRA	While you are enrolled in an HDHP, the Plan will contribute or “pass through” a portion of the health plan premium to your HSA/HRA. If you are eligible for an HSA, the premium contributions will be funded to your account on a monthly basis. For an HRA, the premium contribution or “pass through” will be funded annually. The maximum that may be contributed to your HSA/HRA may not exceed the amount of the deductible, which is \$1,100 for Self Only or \$2,200 for Self and Family.

Section 11. FEHB Facts

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- 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 benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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 2008 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 2007 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.

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

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

Upon divorce

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

Temporary Continuation of Coverage (TCC)

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

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of three Federal programs that complement the FEHB Program.

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

Second, the **Federal Flexible Spending Account 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.

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). 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.

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. **Annuitants are not eligible to enroll.**

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

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHB or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHB or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses for your child(ren) under age 13 or for dependants unable to care for themselves that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

Where can I get more information about FSAFEDS?

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

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

- Important Information** The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.
- Dental Insurance** Dental plans provide a comprehensive range of services, including all the following:
- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
 - Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
 - Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
 - Class D (Orthodontic) services with up to a 24-month waiting period.
- Vision Insurance** Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
- Additional Information** You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.
- How do I enroll?** You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

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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 Georgia, Inc. - 2008

- **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; \$20 specialist	21
Services provided by a hospital:		
• Inpatient	\$250 per admission copay	40
• Outpatient	\$75 per visit	41
Emergency benefits:		
• In-area	\$75 per visit	45
• Out-of-area	\$75 per visit	45
Mental health and substance abuse treatment:	Regular cost sharing	47
Prescription drugs:		
• Generic	\$10/\$16 (Plan / community pharmacy)	51
• Brand name	\$25/\$31 (Plan / community pharmacy)	51
Dental care:	Various copayments based upon procedure rendered.	55
Vision care:	Refractions: \$20 per office visit	28
Special features:	Flexible benefits option; 24 hour advice line; Services for the deaf, hard of hearing or speech impaired; Centers of Excellence; Travel benefit; Smoking cessation; Services from other Kaiser Permanente or allied plans	56
Protection against catastrophic costs (out-of-pocket maximum):	There is no catastrophic protection out-of-pocket maximum	16

Summary of benefits for the Standard Option of the Kaiser Foundation Health Plan of Georgia, Inc. - 2008

- 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.
- Below, an asterisk (*) means the item is subject to the calendar year deductible.

Standard Option Benefits	You Pay	Page
Deductibles:		
• Covered services	\$500 per person and \$1,500 per family	21
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Copay: \$20 primary care; \$30 specialist	21
Services provided by a hospital:		
• Inpatient	\$250 per day up to \$750 per admission*	40
• Outpatient	20% coinsurance*	41
Emergency benefits:		
• In-area and Out-of-area	\$125 per visit	45
Mental health and substance abuse treatment:	Regular cost sharing	47
Prescription drugs:		
• Generic	\$20/\$26 (Plan/community pharmacy)	51
• Brand name	\$30/\$36 (Plan/community pharmacy)	51
Dental care:	Various copayments based on procedure	55
Vision care:	Refractions: \$30 per visit	28
Special features:	Flexible benefits option; 24 hour advice line; Services for the deaf, hard of hearing or speech impaired; Centers of Excellence; Travel benefit; Smoking cessation; Services from other Kaiser Permanente or allied plans	56
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$2,500 for Self Only enrollment or \$7,500 for Self and Family enrollment. Some costs do not count toward this protection	16

Summary of benefits for the HDHP of the Kaiser Foundation Health Plan of Georgia, Inc. - 2008

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

In 2008, for each month you are eligible for the HSA, we will deposit \$45.83 per month for Self Only enrollment or \$91.67 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you must satisfy your calendar year deductible of \$1,100 for Self Only and \$2,200 for Self and Family before using your HSA. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$550 for Self Only and \$1,100 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (*) means the item is subject to the \$1,100 calendar year deductible for Self Only or \$2,200 calendar year deductible for Self and Family.

HDHP Benefits	You Pay	Page
In-network medical and dental preventive care	\$15 office visit copayment	70
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	20% coinsurance*	72
Services provided by a hospital:		
• Inpatient	20% coinsurance*	86
• Outpatient	20% coinsurance*	87
Emergency benefits:		
• In-area and Out-of-area	20% coinsurance*	91
Mental health and substance abuse treatment:	20% coinsurance*	92
Prescription drugs:		
• Generic/Brand name	20% coinsurance*	96
Dental preventive care:	30% of the dentist's usual and customary fee schedule or the fee actually charged, whichever is less.	70
Vision care:	20% coinsurance*	76
Special features:	Flexible benefits option; 24 hour advice line; Services for the deaf, hard of hearing or speech impaired; Centers of Excellence; Travel benefit; Smoking cessation	101
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$3,000 for Self Only enrollment or \$6,000 for family enrollment. Some costs do not count toward this protection	16

Notes

Notes

Notes

2008 Rate Information for Kaiser Foundation Health Plan of Georgia, Inc.

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

Postal Category 1 rates apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other career non-law enforcement Postal Service employees. *PostalEASE*, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees, RI 70-2*, to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center
 1-877-477-3273, Option 5
 TTY: 1-866-260-7507

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 *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	F81	\$140.55	\$46.85	\$304.52	\$101.51	\$23.42	\$21.08
High Option Self and Family	F82	\$321.86	\$107.28	\$697.35	\$232.45	\$53.64	\$48.28
Standard Option Self Only	F84	\$101.48	\$33.83	\$219.88	\$73.29	\$16.91	\$15.22
Standard Option Self and Family	F85	\$232.40	\$77.47	\$503.54	\$167.85	\$38.73	\$34.86
HDHP Option Self Only	GW1	\$113.88	\$37.96	\$246.74	\$82.25	\$18.98	\$17.08
HDHP Option Self and Family	GW2	\$256.01	\$85.34	\$554.69	\$184.90	\$42.67	\$38.40