

Kaiser Foundation Health Plan of Georgia, Inc.

my.kaiserpermanente.org/federalempleyees



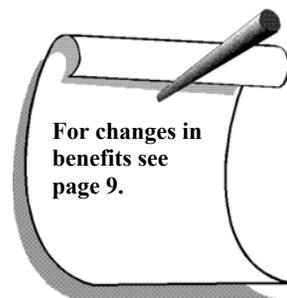
KAISER PERMANENTE®

2005

A Health Maintenance Organization

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 2005 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

Special notice: This Plan is offering a Standard Option for the first time under the Federal Employees Health Benefits Program during the 2005 Open Season.



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



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.html, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay C. James".

Kay Coles James

Director



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

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

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

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

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

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

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

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

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

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

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

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.

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

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

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

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

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

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

Table of Contents

Introduction	3
Plain Language	3
Stop Health Care Fraud!	3
Preventing medical mistakes	5
Section 1. Facts about this HMO plan	7
How we pay providers	7
Your Rights	7
Language Interpretation Services	8
Service Area	8
Section 2. How we change for 2005	9
Program-wide changes	9
Changes to this Plan	9
Section 3. How you get care	10
Identification cards	10
Where you get covered care	10
• Plan providers	10
• Plan facilities	10
What you must do to get covered care	10
• Primary care	10
• Specialty care	11
• Hospital care	12
• Rescheduling of services	12
Circumstances beyond our control	13
Services requiring our prior approval	13
Section 4. Your costs for covered services	14
Copayments	14
Deductible	14
Pharmacy deductible	14
Coinsurance	15
Fees when you fail to make your copayment or coinsurance	15
Missed appointment fee	15
Your catastrophic protection out-of-pocket maximum	15
Section 5. Benefits – OVERVIEW (See page 9 for how our benefits changed this year and pages 76 and 77 for a benefits summary.)	16
Section 5(a) Medical services and supplies provided by physicians and other health care professionals	18
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals	32
Section 5(c) Services provided by a hospital or other facility, and ambulance services	36
Section 5(d) Emergency services/accidents	40
Section 5(e) Mental health and substance abuse benefits	43
Section 5(f) Prescription drug benefits	46
Section 5(g) Special features	50
• Flexible benefits option	50
• 24 hour nurse line	50
• Services for deaf and hearing impaired	50
• High risk pregnancies	50
• Centers of Excellence	50
• Travel benefit	51

• Smoking cessation	51
• Services from other Kaiser Permanente plans	52
Section 5(h) Dental benefits	53
Section 5(i) Non-FEHB benefits available to Plan members	55
Section 6. General exclusions – things we don’t cover	56
Section 7. Filing a claim for covered services	57
Section 8. The disputed claims process	58
Section 9. Coordinating benefits with other coverage	60
When you have other health coverage	60
What is Medicare?	60
• Should I enroll in Medicare?	60
• If you enroll in Medicare Part B	61
• The Original Medicare Plan (Part A or Part B)	61
• Medicare Advantage	63
TRICARE and CHAMPVA	64
Workers’ Compensation	65
Medicaid	65
When other Government agencies are responsible for your care	65
When others are responsible for injuries	65
Section 10. Definitions of terms we use in this brochure	66
Section 11. FEHB Facts	68
Coverage information	68
• No pre-existing condition limitation	68
• Where you can get information about enrolling in the FEHB Program	68
• Types of coverage available for you and your family	68
• Children’s Equity Act	69
• When benefits and premiums start	69
• When you retire	69
When you lose benefits	69
• When FEHB coverage ends	69
• Spouse equity coverage	70
• Temporary Continuation of Coverage (TCC)	70
• Converting to individual coverage	70
• Getting a Certificate of Group Health Plan Coverage	70
Section 12. Two Federal Programs complement FEHB benefits	71
The Federal Flexible Spending Account Program – <i>FSAFEDS</i>	71
The Federal Long Term Care Insurance Program	74
Index	75
Summary of benefits for Kaiser Foundation Health Plan of Georgia, Inc.	76
2005 Rate Information for Kaiser Foundation Health Plan of Georgia, Inc.	78

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, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 9. Rates are shown on the back cover 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 fehbwcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

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

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

If the provider does not resolve the matter, call us at 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.**

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

3. **Get the results of any test or procedure.**

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

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

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

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

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

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.html. 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/consumer.html. 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.

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.

How we pay providers

We contract with The Southeast Permanente Medical Group, Inc. (a for-profit Georgia corporation) and hospitals to provide the benefits in this brochure. Your medical group physicians are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee-for-service, and incentive payments. Other Plan providers accept a negotiated payment from us. You will only be responsible for your deductible, copayments or coinsurance. If you would like further information about the way Kaiser Permanente physicians are paid to provide or arrange medical and hospital care for you, please call us at 404/261-2590.

Your Rights

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

- Kaiser Foundation Health Plan of 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 270,000 members in the metro-Atlanta area.
- In 2004, Kaiser Permanente's HMO and Medicare plans 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, judgement, 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 accord 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, Member Services Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736. You may also contact us by visiting our Web site at my.kaiserpermanente.org/federalemmployees.

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.

NOTE: Here are some things to keep in mind.

If you are currently enrolled in, or plan to enroll in, our Senior Advantage plan, the service area requirements may be different from the service area shown above for other federal members.

To enroll in the Senior Advantage plan you must live in the following counties: Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, and these zip codes in Paulding county – 20134, 30127, and 30141.

If you lose eligibility for the Kaiser Permanente Senior Advantage plan because you move outside the Senior Advantage service area, you will no longer be entitled to the enhanced benefits under Section 9 of this brochure.

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 service area, you can receive virtually all of the benefits of this Plan at any other Kaiser Permanente facility, including our mail order prescription program. You must pay the charges or copayments imposed by the Kaiser Permanente Plan you are visiting, with the exception of mail order prescriptions which are administered by your home Plan. See Section 5(g), Special Features, for more details. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described on page 51; and for emergency care obtained from any non-Plan provider, as described on page 40. 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 2005

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

Program-wide changes

- In Section 9, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program

Changes to this Plan

- We have added a new Standard Option plan.
- If you were enrolled in our 2004 plan, you will automatically continue in Kaiser Permanente High Option in 2005, unless you request a change from your employing or retirement office.

The following changes apply to our High Option plan:

- Your share of the non-Postal premium will increase by 9.7% for Self Only or 9.7% for Self and Family.
- We removed the catastrophic protection out-of-pocket maximum .
- We increased the non-routine prenatal care copayment to \$15 per visit.
- We increased the allergy injection copayment to \$10 per visit.
- We now cover devices and equipment for the treatment of sexual dysfunction disorders under orthopedic and prosthetic devices and durable medical equipment (DME).
- We increased your prescription drug copayment for brand name drugs. Your copayment is now \$20 for brand name drugs obtained at Kaiser Permanente medical center pharmacies, and \$26 for brand name drugs obtained at designated community pharmacies. The copayment for generic drugs has not changed.
- We changed the dispensing limit for insulin to a 30-day supply per prescription drug copayment.
- We increased the copayment for amino acid-modified products and immunosuppressant drugs to be the same as the prescription drug copayment.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your 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 Kaiser Permanente, Member Services Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736. You may also request replacement cards through our Web site at my.kaiserpermanente.org/federalemmployees.

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 list Plan providers in the physician directory, which we update periodically. The list is also on our Web site my.kaiserpermanente.org/federalemmployees.

• Plan facilities

Plan facilities include our medical offices, as well as hospitals and other facilities in our service area that we contract with to provide covered services to our members. Other services, such as physical therapy, laboratory, and X-ray, are available at Plan facilities and other designated locations. Hospital care is provided at local community hospitals. We list these in the physician directory, which we update periodically. The list is also on our Web site.

You must receive your health services at Plan facilities, except if you have an emergency. If you are visiting another Kaiser Permanente service area, you may receive health care services at those Kaiser Permanente facilities. Under the circumstances specified in this brochure, you may receive follow-up or continuing care while you travel anywhere.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member should choose a primary care physician. 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 Member Services Department at 404/261-2590 (locally), 800/ 611-1811 (long distance), or 800/255-0056 (TTY number).

• Primary care

We require you to choose a primary care physician when you enroll. Every member of your family should have his or her own 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. That physician will be listed in our records as your primary care physician until you make a selection and inform us of your decision.

When choosing your primary care physician, keep in mind that your choice may determine where you will receive specialty care. Your primary care physician has an established relationship with a specific group of specialty care physicians with whom he or she works on a regular basis. By referring only to a select group of specialists, your primary care physician is better able to ensure that you receive quality care.

You may select your primary care physician from the Medical Group Physicians or from a contracted 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. Your primary care physician can be a family practitioner, internist, or pediatrician. Adults should select an internal medicine or family practice physician. Parents can choose a pediatrician or family 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 wish to be treated by a physician at a Kaiser Permanente medical center or by another Affiliated Community Physician, you should select that individual as your new primary care physician before scheduling treatment.

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. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

To learn how to choose or change your primary care physician, call our Member Services Department at 404/261-2590 (locally), 800/ 611-1811 (long distance), or 800/255-0056 (TTY number).

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. Under the Standard Option plan, you 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 our 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 in the hospital when your enrollment in our Plan begins, call our Member Services Department immediately at 404/261-2590. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

• 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 Member Services 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
- Outpatient procedures and services:
 - Ambulatory Surgery
 - Biofeedback or other pain management treatment
 - Comprehensive outpatient rehabilitation facility services
 - Cryosurgery of the prostate
 - Dialysis
 - Drugs: Botox injections, human growth hormone, Panretin, Targretin, Actimmune, Flolan, Tracleer, Fuzeon, Amevive, Raptiva, Enbrel, Remicade, Humira, Remodulin and Xolair
 - Durable medical equipment, and orthopedic and prosthetic devices
 - Epidural steroid injections
 - Home Health Care
 - Hospice care
 - Hyperbaric oxygen (HBO) treatment
 - Implantable cardiac defibrillators (AICD)
 - Intrathecal and epidural infusion pumps
 - Lithotripsy
 - PET Scans
 - Prostate seed implants
 - Sclerotherapy or other varicose vein treatment
 - Speech therapy, physical therapy, occupational therapy
 - Spinal cord stimulation
 - Transplant related services
 - Uvulopalatopharyngoplasty
- Any request for non-Plan provider

Section 4. Your costs for covered services

You must share the costs of some services. You are responsible for:

Copayments

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

Example: When you see your primary care physician you pay a copayment of \$15 per office visit and when you go in the hospital, you pay \$250 per admission.

Deductible

Standard Option plan:

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.

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.

High Option plan:

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

Pharmacy deductible

Standard Option plan:

The fixed amount of covered expenses you must incur for certain prescribed drugs (except IV fluids and medications for home use, drugs for covered infertility treatment, and drugs for covered sexual dysfunction treatment) before we start paying benefits for covered prescription drugs. The annual pharmacy deductible for the Standard Option is \$100 per person.

Once the annual pharmacy deductible is met, you pay your applicable prescription drug copayment.

Each of your covered family members must meet their individual annual pharmacy deductible before we pay any prescription drug benefit. This pharmacy deductible is calculated on a calendar year basis and does not carry-over from year to year. Once your pharmacy deductible has been met, you will pay your prescription drug copayment. If you are filling multiple prescriptions or refills, the deductible will be calculated in the order processed.

Please note: Payments made for prescription drugs will be applied *only* to the pharmacy deductible and accumulate separately from the calendar year deductible for covered medical services.

High Option plan:

We do not have a pharmacy deductible in the High Option plan.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for certain services that you receive.

Example: In our Plan, 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

If you do not cancel your appointment with your Plan provider at least 24 hours in advance of the appointment, you may be required to pay an administrative fee of \$25 and 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

Standard Option Plan:

After your copayments and coinsurance total \$2,000 per person or \$6,000 per family enrollment in any calendar year, you do not have to pay any more for certain covered services. However, the following do not count toward your catastrophic protection out-of-pocket maximum, and you must pay them 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 and the annual pharmacy deductible do not count toward your catastrophic protection out-of-pocket maximum.

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

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

Section 5. Benefits – OVERVIEW

(See page 9 for how our benefits changed this year and pages 76 and 77 for a benefits summary.)

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. 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 our benefits, contact us at 404/261-2590 or at our Web site at my.kaiserpermanente.org/federalemployees.

Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	18
Diagnostic and treatment services.....	18
Lab, X-ray and other diagnostic tests.....	19
Preventive care, adult.....	19
Preventive care, children.....	20
Maternity care.....	21
Family planning.....	21
Infertility services.....	22
Allergy care.....	23
Treatment therapies.....	23
Physical and occupational therapies.....	24
Speech therapy.....	25
Hearing services (testing, treatment, and supplies).....	25
Vision services (testing, treatment, and supplies).....	26
Foot care.....	26
Orthopedic and prosthetic devices.....	27
Durable medical equipment (DME).....	28
Home health services.....	29
Chiropractic.....	30
Alternative treatments.....	30
Educational classes and programs.....	31
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	32
Surgical procedures.....	32
Reconstructive surgery.....	33
Oral and maxillofacial surgery.....	34
Organ/tissue transplants.....	34
Anesthesia.....	35
Section 5(c) Services provided by a hospital or other facility, and ambulance services.....	36
Inpatient hospital.....	36
Outpatient hospital or ambulatory surgical center.....	38
Extended care benefits/Skilled nursing care facility benefits.....	38
Hospice care.....	39
Ambulance.....	39
Section 5(d) Emergency services/accidents.....	40
Emergency within our service area.....	41
Emergency outside our service area.....	41
Ambulance.....	42
Section 5(e) Mental health and substance abuse benefits.....	43
Mental health and substance abuse benefits.....	43
Section 5(f) Prescription drug benefits.....	46
Covered medications and supplies.....	48
Section 5(g) Special features.....	50
Flexible benefits option.....	50

24 hour nurse line	50
Services for deaf and hearing impaired.....	50
High risk pregnancies	50
Centers of excellence	50
Travel benefit.....	51
Smoking cessation	51
Services from other Kaiser Permanente plans	52
Section 5(h) Dental benefits.....	53
Accidental injury benefit.....	53
Dental benefits	53
Section 5(i) Non-FEHB benefits available to Plan members.....	55
Summary of benefits for Kaiser Foundation Health Plan of Georgia, Inc. - 2005.....	76
2005 Rate Information for Kaiser Foundation Health Plan of Georgia, Inc.	78

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

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

**I
M
P
O
R
T
A
N
T**

- 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 some 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 costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Different copayments apply for primary care visits and specialty care visits in the Standard Option. 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 shown in Section 3 to be sure which services and supplies require preauthorization.
- Note: We waive or lower the office visit charge when you enroll in our Medicare Advantage High Option plan and assign your Medicare benefits to the Plan.

**I
M
P
O
R
T
A
N
T**

Benefit Description	You pay	
<p>Note: The Standard Option plan calendar year deductible applies to some benefits in this Section. We say “(No deductible)” when it does not apply.</p>		
Diagnostic and treatment services	Standard Option	High 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 	\$20 per visit to your primary care provider \$30 per visit to a specialist (No deductible)	\$15 per visit
<ul style="list-style-type: none"> • In a Plan After-Hours Care Center or any other urgent care center designated by the Plan 	\$40 per visit (No deductible)	\$30 per visit
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	20% of our allowance after you have met your calendar year deductible	Nothing

Diagnostic and treatment services – continued on next page

Diagnostic and treatment services (continued)	You pay – Standard Option	You pay – High Option
<ul style="list-style-type: none"> • At home 	Nothing (No deductible)	Nothing
<ul style="list-style-type: none"> • Certain procedures received during an office visit, such as cardiac stress tests, nerve conduction studies, pulmonary function tests and loop electrode excision procedures (LEEP). 	20% of our allowance after you have met your calendar year deductible	Nothing
Lab, X-ray and other diagnostic tests		
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Pathology • X-rays • Non-routine Mammograms • CT scans, MRI, PET scans, nuclear medicine • Ultrasound 	20% of our allowance after you have met your calendar year deductible	Nothing
<ul style="list-style-type: none"> • Electrocardiogram and EEG 	Nothing (No deductible)	Nothing
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 Pap test 	\$20 per visit to your primary care provider \$30 per visit to a specialist (No deductible)	\$15 per visit
<ul style="list-style-type: none"> • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Double contrast barium enema – every five years starting at age 50 – Colonoscopy screening – every ten years starting at age 50 	20% of our allowance after you have met your calendar year deductible	\$15 per visit
<ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 	Nothing	Nothing
Notes: <ul style="list-style-type: none"> • You should consult with your physician to determine what screenings are appropriate for you. • You pay only one copayment if you receive your routine screening on the same day as your office visit. 		

Preventive care, adult - continued on next page

Preventive care, adult <i>(continued)</i>	You pay – Standard Option	You pay – High Option
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 Note: In addition to routine screening, we cover mammograms when medically necessary to diagnose or treat your illness.	Nothing (No deductible)	Nothing
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	Nothing if you receive these services during your office visit; otherwise \$20 per visit. (No deductible)	Nothing if you receive these services during your office visit; otherwise \$15 per visit.
<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>
Preventive care, children		
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child preventive care visits (up to 2 years of age) 	Nothing if you receive these services during your office visit; otherwise \$20 per visit. (No deductible)	Nothing if you receive these services during your office visit; otherwise \$15 per visit.
<ul style="list-style-type: none"> • Services, such as: <ul style="list-style-type: none"> – Eye screenings to determine the need for vision correction – Hearing screenings to determine the need for hearing correction • Examinations done on the day of immunizations • Well-child care charges for routine examinations, and care (age 2 and over) 	\$20 per visit (No deductible)	\$15 per visit
<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>

Maternity care	You pay – Standard Option	You pay – High Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Routine prenatal care visits (obstetrician, nurse midwife, and OB nurse practitioner) • First postnatal care visit 	<p>Nothing (No deductible)</p>	<p>Nothing</p>
<ul style="list-style-type: none"> • All other visits during pregnancy (such as visits to genetics counselors and perinatologists) 	<p>\$30 per visit (No deductible)</p>	<p>\$15 per visit</p>
<ul style="list-style-type: none"> • Delivery <p>Notes: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your plan physician 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)). 	<p>20% of our allowance after you have met your calendar year deductible (See Section 5(c) for Hospital charges)</p>	<p>Nothing</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Family planning		
<p>A range of voluntary family planning services, such as:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5(b)) • Information on birth control <p>Note: We cover surgically implanted contraceptives, diaphragms, injectable contraceptive drugs, intrauterine devices (IUDs) and oral contraceptives under your prescription drug benefit. See Section 5(f).</p>	<p>\$20 per visit to your primary care provider* \$30 per visit to a specialist* (*No deductible) 20% of our allowance for surgical procedures after you have met your calendar year deductible</p>	<p>\$15 per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Infertility services	You pay – Standard Option	You pay – High Option
<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. 	50% of our allowance after you have met your calendar year deductible	50% of our allowance
<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) • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under your prescription drug benefits. See Section 5(f).</p>	50% of our allowance (No deductible)	50% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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>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> 	<i>All charges</i>	<i>All charges</i>

Allergy care	You pay – Standard Option	You pay – High Option
Testing	20% of our allowance after you have met your calendar year deductible	\$15 per visit
Allergy injections (allergy treatment)	\$10 per visit (No deductible)	\$10per visit
Allergy serum	Nothing (No deductible)	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>	<i>All charges</i>
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 Section 5(b).</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis <p>Notes:</p> <ul style="list-style-type: none"> • We waive dialysis office visit charges if you enroll in Medicare Part B and assign your Medicare benefits to us. • Growth hormone is covered under the prescription drug benefit. • We only cover GHT when we preauthorize the treatment. 	\$30 per visit (No deductible)	\$15 per visit
<ul style="list-style-type: none"> • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy 	Nothing at home \$30 per visit in physician’s office (No deductible)	Nothing at home \$15 per visit in physician’s office
<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>

Physical and occupational therapies	You pay – Standard Option	You pay – High Option
<p>If, in the judgment of a Plan physician, significant improvement is achievable within a two-month period, two consecutive months of therapy per condition:</p> <ul style="list-style-type: none"> • Physical therapy by qualified physical therapists to restore bodily function when you have a total or partial loss of bodily function due to illness or injury • Occupational therapy by occupational therapists to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life <p>Note: If you have not received 20 or more outpatient visits within the two-month period that started with your first visit to a therapist, we may continue your therapy for up to 20 outpatient visits per therapy per condition.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction is provided for up to 12 weeks or 36 visits • Comprehensive outpatient rehabilitation facility services are provided up to two months per condition. Outpatient rehabilitation, including diagnostic and restorative services, providing a program of physical, speech, occupational, respiratory therapy, social and psychological services, and other items and services that are medically necessary for rehabilitation. The two month limit applies to all inpatient and outpatient comprehensive rehabilitation services you may receive for the same condition. 	<p>20% of our allowance after you have met your calendar year deductible</p>	<p>\$15 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term physical therapy or occupational therapy</i> • <i>Exercise programs</i> • <i>Cognitive rehabilitation programs</i> • <i>Vocational rehabilitation programs</i> • <i>Therapies done primarily for education purposes</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Speech therapy	You pay – Standard Option	You pay – High Option
<p>Two consecutive months of therapy per condition:</p> <ul style="list-style-type: none"> • Speech therapy by speech therapists when medically necessary <p>Note: If you have not received 20 or more outpatient visits within the two-month period that started with your first visit to a therapist, we may continue your therapy for up to 20 outpatient visits per therapy per condition.</p>	<p>20% of our allowance after you have met your calendar year deductible</p>	<p>\$15 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</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>
Hearing services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> • Hearing test to determine the need for hearing correction • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	<p>\$30 per visit</p> <p>(No deductible)</p>	<p>\$15 per visit</p>
<ul style="list-style-type: none"> • Audiometric exams 	<p>20% of our allowance after you have met your calendar year deductible</p>	<p>\$15 per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, tests to determine their effectiveness and examinations for them</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Vision services (testing, treatment, and supplies)	You pay – Standard Option	You pay – High Option
<ul style="list-style-type: none"> • Eye refractions for eyeglasses (to provide written lens prescription) • Diagnosis and treatment of diseases of the eye 	\$30 per visit (No deductible)	\$15 per visit
<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>Any 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>	<i>All charges</i>
Foot care		
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$20 per visit to your primary care provider \$30 per visit to a specialist (No deductible)	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges</i>	<i>All charges</i>

Orthopedic and prosthetic devices	You pay – Standard Option	You pay – High 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 	<p>20% of our allowance after you have met your calendar year deductible</p>	<p>20% of our allowance</p>
<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 Section 5(b) for coverage of the surgery to insert the device.</p>	<p>Nothing (No deductible)</p>	<p>Nothing</p>
<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>External and internally implanted hearing aids</i> • <i>Experimental or research equipment</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Durable medical equipment (DME)	You pay – Standard Option	You pay – High Option
<p>Covered DME items include:</p> <ul style="list-style-type: none"> • Hospital beds • Wheelchairs, except motorized • Crutches • Walkers • Infant apnea monitors • Oxygen-dispensing equipment • Oxygen <p>Note: We decide whether to rent or purchase the equipment, and we select the vendor. We will repair the equipment without charge, unless the repair is due to loss or misuse. You must return the equipment to us or pay us the fair market price of the equipment when it is no longer prescribed.</p>	<p>20% of our allowance after you have met your calendar year deductible</p>	<p>20% of our allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheel chairs</i> • <i>Comfort, convenience, or luxury equipment or features</i> • <i>Exercise or hygiene equipment</i> • <i>Non-medical items such as sauna baths or elevators</i> • <i>Modifications to your home or car</i> • <i>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>Devices, equipment, supplies, and prosthetics for the treatment of sexual dysfunction disorders</i> • <i>External and internally implanted hearing aids</i> • <i>Experimental or research equipment</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Home health services	You pay – Standard Option	You pay – High Option
<p>If you are homebound and reside in the service area:</p> <ul style="list-style-type: none"> • You may receive home health services of nurses and health aides, physical or occupational therapists, and speech and language pathologists • Services include oxygen therapy, intravenous therapy, and medications • Note: Your Plan physician will periodically review the program for continuing appropriateness and need. 	<p>Nothing (No deductible)</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>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 Medical Director of the Medical Group or his/her designee determines may be appropriately provided in a Plan facility, skilled nursing facility, or other facility we designate and we provide or offer to provide that care in one of these facilities</i> • <i>Services outside our service area</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Chiropractic	You pay – Standard Option	You pay – High Option
<p>Chiropractic services up to 30 visits per calendar year, for the following services:</p> <ul style="list-style-type: none"> • Evaluation and management of musculoskeletal disorders • Routine chiropractic X-rays provided in the chiropractor’s office (not to exceed 4 views) • Chiropractic adjustments • Appropriate therapies (e.g., hot and cold packs) not to exceed 2 per visit <p>Note: You may see a chiropractor without referral from your Plan physician. Services must be provided from our list of Participating Chiropractors. Please contact us to get the list.</p>	Not Covered	\$15 per visit
<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/preventative 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		
No benefit	<i>All charges</i>	<i>All charges</i>

Educational classes and programs	You pay – Standard Option	You pay – High Option
Training in self-care and preventive care	\$20 per visit	\$15 per 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 classes	Charges vary (\$0 to \$75 for most classes)	Charges vary (\$0 to \$75 for most classes)
<p>Quit Smart Smoking Cessation Program</p> <p>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 vouchers for nicotine patches</p> <p>Georgia tobacco Quit Line</p> <p>The Quit Line is a toll-free telephone resource for people who want to quit using tobacco. Callers will receive screening, counseling, and referral 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 patches (with 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 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

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

**I
M
P
O
R
T
A
N
T**

- 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 some 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 costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 to be sure which services and surgeries require preauthorization .

**I
M
P
O
R
T
A
N
T**

Benefit Description

You pay

Note: The Standard Option plan calendar year deductible applies to some benefits in this Section. We say “(No deductible)” when it does not apply.

Surgical procedures	Standard Option	High Option
<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 • Pre-surgical testing • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Diagnostic colonoscopy • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over 	<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>\$15 per office visit</p> <p>Nothing for hospital or ambulatory surgical center physician and professional services</p> <p>See Section 5(c) for facility charges.</p>

Surgical procedures - continued on next page

Surgical procedures (continued)	You pay – Standard Option	You pay – High Option
<ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See Section 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs). • Other implanted time-release drugs • Treatment of burns <p>Note:</p> <ul style="list-style-type: none"> • Drugs and devices are covered under Section 5(f) 	<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>\$15 per office visit</p> <p>Nothing for hospital or ambulatory surgical center physician and professional services</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>Routine treatment of conditions of the foot (Section 5(a)); see Foot care</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Reconstructive surgery</p>		
<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; webbed fingers; and webbed toes. • Treatment of 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 to produce a symmetrical appearance of breasts; - 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>\$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>\$15 per office visit</p> <p>Nothing for hospital or ambulatory surgical center physician and professional services</p> <p>See Section 5(c) for facility charges.</p>

Reconstructive surgery – continued on next page

Reconstructive surgery (continued)	You pay – Standard Option	You pay – High Option
<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 change 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>	<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; • Medical and surgical treatment of TMJ (non-dental); and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$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.</p>	<p>\$15 per office visit Nothing for hospital or ambulatory surgical center physician and professional services 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 and correction of malocclusion</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Organ/tissue transplants		
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Kidney • Liver • Intestinal transplants (small intestine) 	<p>\$30 per visit with specialist Nothing for inpatient surgery (No deductible) See Section 5(c) for facility charges.</p>	<p>\$15 per office visit Nothing for inpatient surgery See Section 5(c) for facility charges.</p>

Organ/tissue transplants – continued on next page

Organ/tissue transplants (continued)	You pay – Standard Option	You pay – High Option
<ul style="list-style-type: none"> • Heart/lung • Kidney/Pancreas • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas 	<p>\$30 per visit with specialist*</p> <p>(*No deductible)</p> <p>20% of our allowance for inpatient surgery after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>	<p>\$15 per office visit</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges.</p>
<p>Note: We cover related medical and hospital expenses of the donor when we cover your transplant.</p>		
<p><i>Not covered:</i></p> <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 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Anesthesia		
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office 	<p>20% of our allowance after you have met your calendar year deductible</p>	<p>Nothing</p>

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

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

I
M
P
O
R
T
A
N
T

- 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 family). The calendar year deductible and plan coinsurance apply to most 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 costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET 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.

I
M
P
O
R
T
A
N
T

Benefit Description	You pay	
<p>Note: The Standard Option plan calendar year deductible applies to most benefits in this Section. We say “(No deductible)” when it does not apply.</p>		
Inpatient hospital	Standard Option	High Option
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: Your physician may prescribe accommodations or private duty nursing (independent nursing) care if it is medically necessary. If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$250 per day up to \$750 per inpatient admission	\$250 per admission

Inpatient hospital - continued on next page

Inpatient hospital <i>(continued)</i>	You pay – Standard Option	You pay – High Option
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma. The collection and storage of autologous blood for elective surgery is covered when authorized by a Plan physician. • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services <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 conditions for which we will provide hospitalization include hemophilia and heart disease. The need for anesthesia, by itself, is not such a condition.</p>	<p>\$250 per day up to \$750 per inpatient admission</p>	<p>\$250 per admission</p>
<ul style="list-style-type: none"> • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	<p>According to the benefit of the specific item you take home, i.e., hospital bed, pharmacy items, etc.</p>	<p>According to the benefit of the specific item you take home, i.e., hospital bed, pharmacy items, etc.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, guest meals, and beds</i> • <i>Private nursing care</i> • <i>Any inpatient dental procedures, except as shown above and in Section 5(h) under dental benefits</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>	<p><i>All charges</i></p>

Outpatient hospital or ambulatory surgical center	You pay – Standard Option	You pay – High Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 	20% of our allowance after you have met your calendar year deductible	\$50 per visit
<i>Not covered: 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>
Skilled nursing care benefits		
<p>Up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate. We cover the following:</p> <ul style="list-style-type: none"> • Physician and nursing services • Room and board • Medical social services • Blood, blood products, and their administration • Durable medical equipment ordinarily furnished by a skilled nursing facility, including oxygen-dispensing equipment and oxygen • Respiratory therapy • Biological supplies • Medical supplies 	Nothing (No deductible)	Nothing
<i>Not covered: Custodial care and care in an intermediate care facility</i>	<i>All charges</i>	<i>All charges</i>

Hospice care	You pay – Standard Option	You pay – High 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 • Services are provided in a Plan approved hospice facility <p>Services include inpatient care, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less.</p> <p>Note: Hospice is a program for caring for the terminally ill that emphasizes supportive services, such as home care and pain control, rather than curative care of the terminal illness. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, physician services, and short-term inpatient care for pain control and acute and chronic symptom management. We also provide counseling and bereavement services for the individual and family members, and therapy for purposes of symptom control to enable the person to continue life with as little disruption as possible. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.</p>	<p>Nothing</p> <p>(No deductible)</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Private duty nursing (independent nursing)</i> • <i>Homemaker services</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Ambulance		
<p>Local professional ambulance service when ordered or authorized by a Plan physician</p>	<p>\$125 per trip</p> <p>(No deductible)</p>	<p>\$75 per trip</p>
<p><i>Not covered: transports that we determine are not medically necessary</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5(d) Emergency services/accidents

I
M
P
O
R
T
A
N
T

Here are some 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.
- 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 costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

I
M
P
O
R
T
A
N
T

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 48 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 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 Member Services Department in the Atlanta area at 404/261-2590, or from other areas at 800/611-1811.

Benefit Description	You pay	
Emergency within our service area	Standard Option	High Option
<p>Emergency care as an outpatient, including physicians' services</p> <ul style="list-style-type: none"> • Emergency care at an urgent care center not designated by the plan • Emergency care in a hospital emergency room <p>Note: Your copayment is waived if you are directly admitted to a hospital from the emergency room.</p>	\$125 per visit	\$75 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care</i> • <i>Non-emergency care</i> 	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area		
<p>Emergency care as an outpatient, including physicians' services</p> <ul style="list-style-type: none"> • Emergency care at a physician's office • Emergency care at an urgent care center • Emergency care in a hospital emergency room • Emergency care in a Kaiser Foundation hospital in another Kaiser Foundation Health Plan service area <p>Notes:</p> <ul style="list-style-type: none"> • See the Travel Benefit for coverage of continuing or follow-up care. • We waive your copayment if you are directly admitted to a hospital from the emergency room. • If you are transferred from emergency department care to an observation bed, there is no additional copayment. • If you are directly admitted as an inpatient after being seen in an emergency department or from an observation bed, your emergency visit copayment will be waived and your inpatient copayment will apply. 	<p>\$125 per visit</p> <p>The amount you would be charged if you were a member in that service area</p>	<p>\$75 per visit</p> <p>The amount you would be charged if you were a member in that service area</p>

Emergency outside our service area – continued on next page

Emergency outside our service area (continued)	You pay – Standard Option	You pay – High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>	<i>All charges</i>
Ambulance		
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	\$125 per trip	\$75 per trip
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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 facility</i> • <i>Transports we determine are not medically necessary</i> 	<i>All charges</i>	<i>All charges</i>

Section 5(e) Mental health and substance abuse benefits

**I
M
P
O
R
T
A
N
T**

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

Here are some important things 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.
- Under Standard Option – The calendar year deductible is \$500 per person (\$1,500 family). The calendar year deductible and plan coinsurance apply to some 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 costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF INPATIENT SERVICES.**

**I
M
P
O
R
T
A
N
T**

Benefit Description	You pay	
<p>Note: The Standard Option plan calendar year deductible applies to some benefits in this Section. We say “(No deductible)” when it does not apply.</p>		
Mental health and substance abuse benefits	Standard Option	High Option
<p>We cover all diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Notes:</p> <ul style="list-style-type: none"> • We cover the services only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan developed by a Plan provider. • OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment in favor of another. 	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<p>Diagnosis and treatment of psychiatric conditions for children, adolescents, and adults. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Outpatient psychiatric treatment, including individual and group therapy visits • Medication evaluation and management 	<p>\$30 per office visit for individual therapy</p> <p>\$15 per visit for group therapy</p> <p>(No deductible)</p>	<p>\$15 per office visit for individual therapy</p> <p>\$7 per visit for group therapy</p>

Mental health and substance abuse benefits – continued on next page

Mental health and substance abuse benefits <i>(continued)</i>	You pay – Standard Option	You pay – High Option
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 	\$30 per office visit for individual therapy \$15 per visit for group therapy (No deductible)	\$15 per office visit for individual therapy \$7 per visit for group therapy
<ul style="list-style-type: none"> • Psychological testing to determine the appropriate psychiatric treatment 	20% of our allowance after you have met your calendar year deductible	\$15 per office visit
Notes: <ul style="list-style-type: none"> • You may see a mental health 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 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"> • Inpatient mental health and substance abuse care • Hospital alternative services, such as partial hospitalization and intensive outpatient psychiatric treatment programs Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan physician.	20% of our allowance for inpatient professional services after you have met your calendar year deductible \$30 per visit for individual therapy* \$15 per visit for group therapy* (*No deductible) See Section 5(c) for facility charges	Nothing for inpatient professional services \$15 per visit for individual therapy \$7 per visit for group therapy See Section 5(c) for facility charges

Mental health and substance abuse benefits – continued on next page

Mental health and substance abuse benefits <i>(continued)</i>	You pay – Standard Option	You pay – High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Care that is not clinically appropriate for the treatment of your condition</i> • <i>Services we have not approved</i> • <i>Intelligence, IQ, aptitude ability, learning 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>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> <p><i>Note: 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.</i></p>	<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

I
M
P
O
R
T
A
N
T

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 the next page.
- 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 pharmacy deductible is \$100 per person. The calendar year pharmacy deductible applies to most benefits in this Section. We added “(No pharmacy deductible)” to show when the calendar year pharmacy deductible does not apply. *Note:* Payments made for prescription drugs will be applied *only* to the pharmacy deductible and accumulate separately from the calendar year deductible for covered medical services.
- Under High Option – 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 Member Services Department at 404/261-2590.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

I
M
P
O
R
T
A
N
T

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:

3. Online, using our Members Only Web site at my.kaiserpermanente.org/federalempleeoes. 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
3. 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 Member Services 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 Member Services 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 Member Services 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 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.

Prescription drug benefits begin on the next page

Benefit Description	You pay	
Note: The Standard Option plan's calendar year pharmacy deductible applies to most benefits in this Section.		
Covered medications and supplies	Standard Option \$100 annual pharmacy deductible per person	High Option No pharmacy deductible
<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 for which a prescription is required by law • Insulin • Diabetic supplies such as glucose test strips, sugar test tape, sugar test tablets, acetone test tablets • Inhalers • Spacer devices • Compounded dermatological preparation prepared by a pharmacist • Oral contraceptive drugs • Diaphragms • Growth hormone therapy (GHT) – for treatment of children with Turner's syndrome or classical growth hormone deficiency • 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 	<p>\$15 per prescription or refill for covered generic drugs obtained at a Plan medical office pharmacy</p> <p>\$21 per prescription or refill for covered generic drugs obtained at a Plan participating community pharmacy</p> <p>\$25 per prescription or refill for covered name brand drugs obtained at a Plan medical office pharmacy</p> <p>\$31 per prescription or refill for covered name brand drugs obtained at a Plan participating community pharmacy</p>	<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>\$20 per prescription or refill for covered name brand drugs obtained at a Plan medical office pharmacy</p> <p>\$26 per prescription or refill for covered name brand drugs obtained at a Plan participating community pharmacy</p>
<ul style="list-style-type: none"> • Disposable needles and syringes for the administration of covered medications 	Nothing	Nothing
<ul style="list-style-type: none"> • Intravenous fluids and intravenous medications for home use 	Nothing (No pharmacy deductible)	Nothing
<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>	<p>\$15 times the number of months the drug is expected to be effective, not to exceed \$200</p>	<p>\$10 times the number of months the drug is expected to be effective, not to exceed \$200</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (<i>continued</i>) Error! Bookmark not defined.	You pay – Standard Option \$100 annual pharmacy deductible per person	You pay – High Option No pharmacy deductible
<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 (No pharmacy deductible)	50% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Drugs and supplies for cosmetic purposes</i> <i>Vitamins and nutritional supplements that can be purchased without a prescription</i> <i>Nonprescription drugs</i> <i>Prescription drugs for which there is a nonprescription equivalent available</i> <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> <i>Medical supplies such as dressings and antiseptics</i> <i>Any packaging other than the dispensing pharmacy’s standard packaging</i> <i>Drugs to enhance athletic performance</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>Packaging of prescription medications is limited to Plan standard packaging; special packaging is not covered</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 to shorten the duration of the common cold</i> 	<i>All charges</i>	<i>All charges</i>

Section 5(g) Special features

Feature	Description
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.
24 hour nurse line	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 404/365-0966 (locally) or 800/611-1811 (long distance) and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>
Services for deaf and hearing impaired	<p>Our hearing and speech impaired TYY number is: 800/255-0056.</p>
High risk pregnancies	<p>Comprehensive Maternity Program. The goal is to significantly reduce the incident of pre-term deliveries and low birth weight babies by prompt interventions utilizing a multidisciplinary team approach.</p> <p>All women receiving prenatal care are assessed at the first provider visit (ideally during the first trimester) for factors associated with high-risk pregnancy. Risk scoring systems are based on a combination of past medical history (particularly reproductive history), current pregnancy events, personal habits during pregnancy, and demographic risks.</p> <p>Although risk scoring can identify some individuals at risk during pregnancy, no scoring system is so effective that those at risk may be safely ignored. Therefore, ongoing assessment must be done for all patients for symptoms and risk factors for pre-term birth.</p> <p>We are not able to implement any aspect of our maternity benefits on a “mandatory” basis. However, because there is no copayment for all routine prenatal and one postnatal visit, we have a 99% compliance with the recommended course of treatment.</p>
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 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>

Feature	Description
<p>Travel benefit</p>	<p>Kaiser Permanente’s travel benefits for Federal employees provide you with outpatient follow-up or continuing medical care when you are temporarily 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 and urgent care benefits 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 • You pay \$25 for each follow-up or continuing care office visit. We deduct this amount from the payment we make to you • We pay no more than \$1200 each calendar year • For more information about this benefit call our Member Services Department at 404/261-2590. • File claims as shown in Section 7. <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>DME</i> • <i>Prescription drugs</i> • <i>Home health services</i>
<p>Smoking cessation</p>	<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"> • Free brochures • Bookmark listing of smoking cessation resources • Quarterly smoking cessation resource outreach mailings to all identified smokers • Smoking cessation self-help booklet for pregnant women • Smoking cessation brochure for teens <p>For more information or to order any of the above materials please call our Member Services Department at 404/261-2590.</p>

Feature	Description
<p>Services from other Kaiser Permanente plans</p>	<p>When you visit the service area of another Kaiser Permanente plan, you are entitled to receive virtually all the services described in this brochure (including our mail order prescription program) at any Kaiser Permanente medical office or medical center. You must pay the charges, coinsurance or copayments imposed by the Kaiser Permanente plan you are visiting, with the exception of mail order prescriptions which are administered by your home Plan. If the Plan you are visiting has a service that differs from the services of this Plan, you are not entitled to receive that service.</p> <p>Some services covered by this Plan, such as artificial reproductive services and the services of specialized rehabilitation facilities, will not be covered if you receive them in other Kaiser Permanente service areas. If a service is limited to a specific number of visits or days, you are entitled to receive only the number of visits or days covered by this Plan.</p> <p>If you are seeking routine, non-emergent, or non-urgent services, you should call the Kaiser Permanente Membership Services department in that service area and request an appointment. You may obtain routine follow-up or continuing care from these plans, even when you have obtained the original services in our service area. If you require emergency services as the result of unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care.</p> <p>At the time you register for services, you will be asked to pay the charges required by the local plan.</p> <p>If you wish to obtain more information about the services available to you from a Kaiser Permanente plan in an area you visit, please call our Member Services Department at 404/261-2590 or 888/865-5813.</p>

Section 5(h) Dental benefits

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

**I
M
P
O
R
T
A
N
T**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care for services listed under “Other dental benefits”. Call Member Services 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 some 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 costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

**I
M
P
O
R
T
A
N
T**

Benefit Description	You pay	
<p>Note: The Standard Option plan calendar year deductible applies to some benefits in this Section. We say “(No deductible)” when it does not apply.</p>		
Accidental injury benefit	Standard Option	High Option
<p>We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury and all services must be completed within 365 days of the injury in order to be covered.</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>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>
Other dental benefits		
<p>We cover non-surgical treatment of temporomandibular joint dysfunction (TMJ), including splints and appliances</p>	<p>50% of our allowance</p> <p>(No deductible)</p>	<p>50% of our allowance</p>

Other dental benefits – continued on next page

Other dental benefits (continued)	You pay – Standard Option	You pay – High Option
<p>The following preventive dental services are covered when provided by a participating Plan dentist:</p> <ul style="list-style-type: none"> • Oral examinations twice a year • Dental prophylaxis (cleaning) twice a year • 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 five years 	<p>30% of the Plan dentist’s usual and customary fee schedule or the fee actually charged, whichever is less</p> <p>(No deductible)</p>	<p>30% of the Plan dentist’s usual and customary fee schedule or the fee actually charged, whichever is less</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>20% of our allowance after you have met your calendar year deductible</p>	<p>Nothing</p>
<p>Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease</p>	<p>20% of our allowance after you have met your calendar year deductible</p>	<p>\$50 per office visit</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(i) 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.

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 services in addition to routine preventive services – such as fillings, crowns and bridges, and orthodontics.

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, 2005, through December 31, 2005.

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

** The semi-annual premium payment is paid directly by you 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 Evidence of Coverage booklet that fully describes the benefits of your dental program. Also included in the packet are 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 at (800) 422-4234. PMI's Customer Automated Link Line is available seven days a week between 2 a.m. and 7 p.m. (ET) or you may speak to a Customer Service representative Monday through Friday between 2 a.m. and 3 p.m. (ET). If you prefer to use the internet to obtain benefit information, you can access the Delta Dental secured internet Web site at www.deltadentalca.org. 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. This program gives you easy access to products and services you can use to enhance your health and improve your quality of life. *SelfWise* offers discounted rates for chiropractic, acupuncture, accupressure, and massage therapy services; discounted products and services from local businesses; vision care discounts, LASIK discounts, discounts from Weight Watchers and discounts at local fitness centers; fee-for-service cosmetic dermatology services; and much more.

Note: Keep in mind that these programs are discount programs. They are not a part of your FEHBP benefits. These discounted programs are made available to all enrollees and family members who are members of Kaiser Permanente.

For more information about our *SelfWise* Program or for a *SelfWise* brochure, contact our Member Services Department at 404/261-2590.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *Services requiring our prior approval* on page 13.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see Section 5(d)); services under the Travel Benefit (see Section 5(g)), and services received from other Kaiser Permanente plans (see Section 5(g));
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest ;
- Services, drugs, or supplies 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 HCFA-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 receive outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- 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 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:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Kaiser Foundation Health Plan of Georgia, Inc., Attention: Appeals Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta GA 30305-1736; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</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; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

The disputed claims process *(continued)*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

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.

5

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

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

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

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

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

- 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 have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage”.

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. If we are the secondary payer, and you 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.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

• 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 both 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 health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

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

If you enroll in Medicare Part B, we require you to assign your Medicare Part B benefits to the Plan for its services.

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

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

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.

Claims process when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 404/233-3700 (locally), 800/232-4404 (long distance) and 800/255-0056 (TTY line) or see our Web site at my.kaiserpermanente.org/federalemmployees.

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

(Primary payer chart begins on next page.)

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

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

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

- **Medicare Advantage**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs.

To learn more about enrolling in a Medicare Advantage plan, 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 one of our Medicare Advantage plans, Kaiser Permanente Senior Advantage High Option or Standard Option, and also remain enrolled in our FEHB Plan. There is no additional premium to enroll in Senior Advantage. If you would like information about our Medicare Advantage plan, please call 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).

If you choose to enroll in the Kaiser Permanente Senior Advantage High Option plan, we will waive or lower some of your copayments and make some benefit enhancements to your coverage. **The waived or lowered copayments and benefit enhancements apply only to Senior Advantage High Option plan members.** Your Kaiser Permanente Senior Advantage High Option-FEHB benefits that we lowered or waived are:

- **Physician office visits:** \$10 copayment for physician/specialist visit
- **Preventive care:** \$10 copayment per visit for most adult preventive care services; no copayment for mammograms
- **Routine physicals and hearing exams:** \$10 copayment per visit
- **Inpatient hospital:** \$100 per admission
- **Outpatient mental health and substance abuse:** \$10 copayment per visit
- **Prescriptions:**
 - \$5 for each generic prescription obtained at a Plan medical office pharmacy
 - \$11 for each generic prescription obtained at a Plan participating community pharmacy
 - \$15 for each name brand prescription obtained at a Plan medical office pharmacy
 - \$21 for each name brand prescription obtained at a Plan participating community pharmacy
- **Dialysis:** no copayments
- **Durable medical equipment:** 20% of our allowance
- **Orthopedic and prosthetic devices:** 20% of our allowance

- **Vision Services:**

- \$10 copayment for one routine eye exam each year
- Up to an allowance of \$100 for eyeglass lenses and frames; cosmetic contact lenses and medically necessary contact lenses once every 24 months.
- Up to an allowance of \$60 for single vision eyeglass or contact lenses and \$90 for multifocal lenses for replacement lenses for changes in prescription of at least .50 diopter within 12 months
- An allowance is applied toward the total expense of an item that is covered. If the cost of the item you select exceeds the allowance, you will pay the difference. You may only use your allowance one time, which is at the time you order your initial eyeglass lenses, frames, or contact lenses.

You will also enjoy:

- Health/Wellness Education: \$10 copayment for disease-specific health education classes (costs may vary for wellness classes)
- No deductibles and virtually no paperwork
- On-line access to health information and resources at our award- winning members only Web site
- Quarterly member communication in our "Senior Outlook" magazine
- Customized Senior Advantage new member orientation.

For information on Kaiser Permanente's Senior Advantage Standard Option plan benefits, 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).

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 lower or waive any of our copayments or coinsurance. 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.

**TRICARE and
CHAMPVA**

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 14.
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 page 14.
Durable medical equipment	Durable medical equipment (DME) is equipment that is intended for repeated use, medically necessary, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, designed for prolonged use, appropriate for use in the home, and serves a specific therapeutic purpose in the treatment of an illness or injury.
Experimental or investigational services	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. When the service or supply, including a drug: (1) has not been approved by the FDA; or (2) is the subject of a new drug or new device application on file with the FDA; or (3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or (4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or (5) is subject to the approval or review of an Institutional Review Board; or (6) requires an informed consent that describes the service as experimental or investigational; then this Plan considers that service supply or drug to be experimental, and not covered by the Plan.
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."
Medical necessity	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

Our allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: When you receive services or supplies from Plan providers, it is the amount that we set for the services or supplies if we were to charge for them. When you receive services from non-Plan providers, we determine the amount that we believe is usual and customary for the service or supply, and compare it to the charges. Our allowance is based upon the reasonableness of the charges. If the charges exceed what we believe is reasonable, you may be responsible for the excess over our allowance in addition to your coinsurance.

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.

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

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

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

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

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

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

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

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

- **Children’s Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 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 2004 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

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

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

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12.Two Federal Programs complement FEHB benefits

Important information

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

The Federal Flexible Spending Account Program – *FSAFEDS*

• What is an FSA?

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

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSAs)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSAs is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSAs up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSAs. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

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

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

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

What is SHPS?

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

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

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

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

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006 to submit claims for eligible expenses.

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

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on pages 76 and 77 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the Standard Option of this plan, typical out-of-pocket expenses include: your office visit copay, prescription drug copay, inpatient hospital copay and your lab and x-rays coinsurance. The Plan does not cover your annual deductible, pharmacy deductible or the coinsurance amounts that you must pay.

Under the High Option of this plan, typical out-of-pocket expenses include: your office visit copay, prescription drug copay, and inpatient hospital copay. The Plan does not cover coinsurance amounts that you must pay, such as 20% of our allowance for durable medical equipment.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

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

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

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

- **Tax credits and deductions**

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

- Health care expenses**

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

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

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

- Dependent care expenses**

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

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

- **Does it cost me anything to participate in FSAFEDS?** No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).
- **Contact us** To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.
 - E-mail: FSAFEDS@shps.net
 - Telephone: 1-877-FSAFEDS (1-877-372-3337)
 - TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

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

Index

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

24 hour nurse line	50	Experimental or investigational	56, 66	Oxygen	37, 38
Accidental injury.....	34	Eyeglasses.....	26	Pap test	19
Accidental injury (dental)	53	Family planning.....	21	PET scans	19
Allergy tests.....	23	Fecal occult blood test	19	Pharmacy deductible	14
Allogeneic (donor) bone marrow transplant.....	35	Flexible benefits option	50	Plan providers.....	7, 10
Ambulance.....	39, 40, 42	Flexible Spending Account (FSA).....	71	Postnatal	21, 50
Anesthesia.....	32, 35	Foot care	26	Preauthorization.....	13
Autologous bone marrow transplant	23, 35	Fraud.....	3, 4	Prenatal.....	21, 50
Biopsy.....	32	General exclusions.....	56	Prescription drugs.....	9, 46
Blood and blood plasma.....	38	HCFSA	72	Preventive care, adult	19
Breast cancer screening.....	20	Hearing.....	20, 25, 28	Preventive care, children	20
Casts.....	37, 38	Home health.....	29	Preventive services	7
Catastrophic protection out-of-pocket maximum	15, 55, 76, 77	Hospice.....	39	Primary care	10
Centers of Excellence	50	Hospital.....	12, 37, 61	Prosthetic devices	33
CHAMPVA	64	Identification card.....	10	Radiation therapy.....	23
Changes for 2005.....	9	Immunizations	20	Room and board	36
Chemotherapy.....	23	Infertility.....	22	Second surgical opinion	18
Chiropractic	30, 55	Insulin	9, 48	Service Area	8
Cholesterol tests.....	19	Long Term Care Insurance Program.....	74	Services from other Kaiser Permanent plans	52
Claims.....	57, 58, 62, 69, 72	Magnetic Resonance Imagings (MRIs)	19	SHPS	72
Coinsurance	15, 63, 66, 72	Mail order prescriptions.....	8, 48	Skilled nursing facility care.....	18
Colorectal cancer screening	19	Mammograms	19	Smoking cessation.....	31
Congenital anomalies.....	32, 33	Mastectomy	33	Specialty care	11
Contraceptive.....	21, 33, 48	Maternity benefits.....	21	Speech therapy	25
Coordination of benefits	60	Maternity program.....	50	Splints.....	37
Copayment.....	14, 66	Medicaid	65	Subrogation	65
Covered charges.....	61	Medically necessary.....	56, 66	Substance abuse.....	43
CT scans.....	19	Medicare	60, 62	Surgery Anesthesia.....	38
Custodial care	66	Original.....	61, 63	Oral	34
Deaf and hearing impaired services.....	50	Members Family	68	Outpatient	38
Deductible.....	14, 55, 63, 66, 72	Mental Health/Substance Abuse Benefits	43	Reconstructive	32, 33
Deductible (pharmacy).....	14	Morbid obesity.....	32	Syringes.....	48
Definitions	66	Newborn care.....	21	Temporary Continuation of Coverage (TCC).....	69
Dental benefits	53, 77	Non-FEHB benefits	55	Transplants	23
Detoxification	44	Nurse Nurse Anesthetist (NA).....	37	Travel benefit	51
Diabetic supplies.....	48	Nurse practitioner	10, 21	Treatment therapies	23
Diagnostic services	18, 37, 43	Nursery charges	21	TRICARE	64
Dialysis	23, 63	Obstetrical.....	21	Urological supplies.....	27
Disputed claims review.....	58	Occupational therapy	24	Vision care.....	77
Donor expenses.....	35	Office visits.....	14	Vision services	20, 26, 63
Dressings.....	37	Oral and maxillofacial surgical.....	34	Well-child care	20
Durable medical equipment	63, 66	Orthopedic devices	9, 27, 63	Workers Compensation	65
Educational classes and programs.....	31	Our allowance.....	67	X-rays.....	19, 37, 38
Effective date of enrollment.....	12	Out-of-pocket expenses	60		
Emergency	40, 56, 57				

Summary of benefits for Kaiser Foundation Health Plan of Georgia, Inc. Standard Option – 2005

- **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 medical or pharmacy deductible.

Benefits	You pay	Page
Deductible		
• Covered services.....	\$500 per person and \$1,500 per family	14
• Pharmacy.....	\$100 per person	14
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office.....	\$20 per primary care visit \$30 per specialty care visit	18
Services provided by a hospital:		
• Inpatient.....	\$250 per day, \$750 maximum per admission *	36
• Outpatient.....	20% coinsurance *	38
Emergency benefits		
• In-area.....	\$125 per visit	41
• Out-of-area.....	\$125 per visit	41
Mental health and substance abuse treatment.....	Regular cost sharing	43
Prescription drugs.....		
• Generic.....	\$100 deductible, then – \$15/\$21 (Plan pharmacy / community pharmacy) *	48
• Name-brand.....	\$25/\$31 (Plan pharmacy / community pharmacy) *	
Dental care.....	Various copayments based on procedure rendered	53
Vision care.....	Refractions: \$30 per visit	26
Special features: Flexible benefits option; 24 hour nurse line; Services for deaf and hearing impaired; High risk pregnancies; Centers of excellence; Travel benefit; Smoking cessation; Services from other Kaiser Permanente Plans		50
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum).....	Nothing after \$2,000/Self Only or \$6,000/Family enrollment per year Some costs do not count toward this protection	15

Summary of benefits for Kaiser Foundation Health Plan of Georgia, Inc. High Option – 2005

- **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.
- The High Option plan has no calendar year deductible.

Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	\$15 per office visit	18
Services provided by a hospital:		
• Inpatient.....	\$250 per admission	36
• Outpatient	\$50 per surgery	38
Emergency benefits		
• In-area.....	\$75 per visit	41
• Out-of-area.....	\$75 per visit	41
Mental health and substance abuse treatment	Regular cost sharing	43
Prescription drugs		
• Generic.....	\$10/\$16 (Plan pharmacy / community pharmacy)	48
• Name-brand	\$20/\$26 (Plan pharmacy / community pharmacy)	
Dental care	Various copayments based on procedure rendered	53
Vision care	Refractions: \$15 per office visit	26
Special features: Flexible benefits option; 24 hour nurse line; Services for deaf and hearing impaired; High risk pregnancies; Centers of excellence; Travel benefit; Smoking cessation; Services from other Kaiser Permanente Plans		50
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	There is no catastrophic protection out-of-pocket maximum	15

2005 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 FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

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

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	F81	\$105.73	\$35.24	\$229.08	\$76.36	\$125.11	\$15.86
High Option Self and Family	F82	\$268.43	\$89.47	\$581.59	\$193.86	\$317.64	\$40.26
Standard Option Self Only	F84	\$79.58	\$26.53	\$172.43	\$57.48	\$94.17	\$11.94
Standard Option Self and Family	F85	\$202.04	\$67.35	\$437.76	\$145.92	\$239.08	\$30.31