

Kaiser Foundation Health Plan of the Northwest

<http://kp.org/feds>



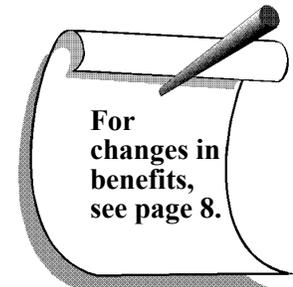
KAISER PERMANENTE

2008

A Health Maintenance Organization (High and Standard Options)

Serving: Portland and Salem, Oregon
Vancouver and Longview, Washington

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 7 for requirements.



*This Plan has excellent accreditation from the NCQA.
See the 2008 Guide for more information on accreditation.*

Enrollment code for this Plan:

- 571 High Option Self Only
- 572 High Option Self and Family
- 574 Standard Option Self Only
- 575 Standard Option Self and Family

Authorized for distribution by the:



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

RI 73-004

Important Notice from Kaiser Foundation Health Plan of the Northwest
About Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

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Introduction

This brochure describes the benefits of Kaiser Foundation Health Plan of the Northwest under our contract (CS 1047) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Kaiser Foundation Health Plan of the Northwest's administrative offices is:

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, Suite 100
Portland, Oregon 97232-2099

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2008, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” or “Plan” means Kaiser Foundation Health Plan of the Northwest.
- 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 fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

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

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us from Portland at 503-813-2000, or from other areas call 1-800-813-2000, or our TTY number at 1-800-735-2900 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, DC20415-1100**

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

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.

- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO Plan

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

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

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

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

General features of our High and Standard Options

How we pay providers

The Northwest Permanente Medical Group provides patient care services through a group capitation arrangement with Kaiser Foundation Health Plan of the Northwest. Northwest Permanente physicians provide approximately 98 percent of primary care services and more than 80 percent of specialty services to members. The Medical Group receives a lump sum incentive payment within a narrow range at the end of the year based on financial performance of the Health Plan and the Medical Group against budget. Compensation for physicians is designed to be competitive in order to recruit and retain quality physicians. Physicians in the Medical Group do not receive financial incentives linked to individual utilization patterns. Instead, approximately ninety percent or more of compensation received by individual physicians is salary; and the remaining amount of variable compensation is based on clinical quality, patient satisfaction, and financial performance of the Medical Group and the Health Plan.

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

Kaiser Foundation Health Plan of the Northwest is a nonprofit corporation. Kaiser Permanente began offering medical services to workers and their families at Grand Coulee Dam in northeastern Washington and later the Kaiser shipyards in Portland, Oregon and Vancouver, Washington during World War II. When the shipyards were closed in 1945, enrollment was opened to the community. This Plan is part of the Kaiser Permanente Medical Care Program, a group of nonprofit organizations and contracting medical groups that serve over 8 million members nationwide. Our Medical Group, Northwest Permanente (a for-profit Oregon-based professional corporation), delivers care in Plan medical facilities throughout Kaiser Foundation Health Plan of the Northwest service area.

In 1995, Kaiser Permanente became the first HMO in Oregon and southwest Washington to receive a three-year, full accreditation from the National Committee for Quality Assurance (NCQA). We were again awarded three-year, full accreditation in 1998. In 2004 we were awarded the highest level of accreditation, known as "Excellent Accreditation." Excellent Accreditation status is awarded to plans whose service and clinical quality meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement, and whose HEDIS (Health Plan Employer Data and Information Set) results are in the highest range of national performance. In 2007, we also received a status of "Distinction" from NCQA on Member Connections Standards in the Quality Plus Program.

All Kaiser Permanente and affiliated hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

All applicants for employment with Northwest Permanente P.C., or Permanente Dental Associates must meet rigorous Kaiser Permanente credentialing standards. Once hired, they undergo periodic review by peers and hospital boards to assure their credentials are up to date and in order.

If you want more information about us, from Portland, call 503-813-2000, or from other areas call 1-800-813-2000 or our TTY number at 1-800-735-2900, or write to Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah, Suite 100, Portland, OR 97232. You may also visit our Web site at <http://kp.org/feds>.

Interpreters are available to assist members who do not speak English. Please see the listing in your *Medical Directory*.

For free language interpretation services, or information about providers who speak languages other than English, call 1-800-324-8010 or our TTY number at 1-800-735-2900.

Your medical and claims records are confidential

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

Service Area

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

These Oregon counties: Columbia, Multnomah, Polk, Yamhill

And these Oregon ZIP codes:

Benton County: 97330, 97331, 97333, 97339, 97370

Clackamas County: 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97055, 97067-68, 97070, 97086, 97089, 97222, 97267-68

Linn County: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389

Marion County: 97002, 97020, 97026, 97032, 97071, 97137, 97301-3, 97305-14, 97317, 97325, 97352, 97362, 97375, 97381, 97383-85, 97392

Washington County: 97005-8, 97062, 97075-78, 97106, 97109, 97113, 97116-17, 97119, 97123-25, 97133, 97140, 97144, 97223-25, 97229, 97281, 97291

These Washington counties: Clark County

And these Washington ZIP codes:

Cowlitz County: 98581, 98603, 98609, 98611, 98616, 98625-26, 98632, 98645, 98649, 98674

Lewis County: 98591, 98593, 98596

Wahkiakum County: 98612, 98647

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente or allied plan service area, you can receive visiting member care from designated providers in the area. 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 in Section 5(g); and for emergency care obtained from any non-Plan provider, as described in Section 5(d). We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If your dependent goes to college outside any Kaiser Permanente service area, they may qualify for the student out-of-area coverage. See page 48. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2008

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

Changes to this Plan

- United States Postal Service non-law enforcement career employees may now be covered either by Postal Category 1 or Postal Category 2 premium rates. See page 78.

Changes to High Option only

- Your share of the non-Postal premium will increase. See page 78.
- Copayments for specialized scans (MRI, CT and PET) will increase from no charge to \$100 per department visit. See page 18.
- Copayments for adult preventive care routine examinations will decrease from \$15 to no charge. See page 18.
- Copayments for well-child office visits will decrease from \$15 to no charge. See page 19.
- Copayments for prenatal office visits will decrease from \$15 to no charge. See page 20.
- Copayment for outpatient surgeries performed in an operating room and for colonoscopy and sigmoidoscopy screenings will increase from \$15 to \$50. See page 18 and 30.

Changes to Standard Option only

- Your share of the non-Postal premium will increase. See page 78.
- Copayments for specialized scans (MRI, CT and PET) will increase from \$20 to \$100 per department visit. See page 18.
- Copayments for adult preventive care routine examinations will decrease from \$20 to no charge. See page 18.
- Copayments for well-child office visits will decrease from \$20 to no charge. See page 19.
- Copayments for prenatal office visits will decrease from \$20 to no charge. See page 20.
- Copayments for multidisciplinary rehabilitation will increase from \$20 to \$30 per day. See page 22.
- Copayment for colonoscopy and sigmoidoscopy screenings will increase from \$20 to \$100. See page 18.
- Copayments for office visits in a hospital emergency department will increase from \$75 to \$100. See page 41.

Changes to Both High and Standard Options

- We changed the multidisciplinary rehabilitation benefit limit from two months to 60 days. See page 22.
- We added coverage for hearing aids (including testing and examinations for them) for children under age 18. The benefit provides coverage for up to \$1,000 for each hearing impaired ear every 36 months. See page 23.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us from Portland at 503-813-2000, or from other areas call 1-800-813-2000 or our TTY number at 1-800-735-2900, or write to us at: Membership Administration, Kaiser Permanente, P.O. Box 921008, Fort Worth, Texas 76121-0008. You may also request replacement cards through our Web site at <http://kp.org/feds>.

Where you get covered care

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

- **Plan providers**

The Plan contracts with Northwest Permanente, P.C. to provide physician services. They practice in medical offices located within our service area. Permanente Dental Associates, an independent group of dentists, provides or arranges dental care for members of the High Option plan.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. Medical centers, medical offices, and dental offices are conveniently located throughout Portland and Salem, Oregon and Vancouver and Longview-Kelso, Washington. We list these facilities and hospitals in the provider directory, which we update periodically. The list is also on our Web site.

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Our Web site has information about our providers. Membership Services can help you too, by telling you who is available and sharing information about them. To choose or change a primary care physician, call Membership Services from Portland at 503-813-2000, or from other areas call 1-800-813-2000 or our TTY number at 1-800-735-2900.

- **Primary care**

Your primary care physician can be a physician, nurse practitioner, or physician assistant in family practice, internal medicine, or pediatrics. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

Specialty care is care you receive in areas other than primary care (as defined above). Your primary care physician will refer you to a specialist for needed care. 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, a woman may see her obstetrician/gynecologist without having to obtain a referral. You may also receive outpatient alcohol and drug treatment, cancer counseling, eye examinations, outpatient mental health, chiropractic, occupational health, and social work services without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan.
- 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 or 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.

Note: Under certain circumstances and for a limited period of time, we may continue to pay for covered services provided by your Kaiser Permanente physician or a physician you have been referred to by your Kaiser Permanente physician, when the physician's contract with us has been terminated. This extension of care is available for a period up to 120 days from the date we notify you of the physician's termination, as long as you are receiving an active course of medically necessary treatment, and your treating physician agrees that it is desirable to maintain continuity of care. Additionally, this extension of coverage is available if you are in the second trimester of pregnancy, until the later of the following dates: the 45th day after the baby's birth, or as long as you are receiving active treatment, not to exceed 120 days from the date you receive notice of the termination. To apply for this continuity of care extension, you must submit a written request to us.

This continuity of care provision is applicable only when your Kaiser Permanente physician or referred physician agrees to adhere to the reimbursement rate applicable at the time of contract termination or an equivalent rate, if the contractual rate was not based on a fee-for-service basis.

- **Hospital care**

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

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Membership Services department immediately from Portland at 503-813-2000, or from other areas call 1-800-813-2000 or our TTY number at 1-800-735-2900. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

Most care and services are not subject to administrative prior authorization. Prior authorization is required for select services such as bariatric surgery, care at skilled nursing facilities, home health and hospice services, referrals to non-Kaiser Permanente physicians, and transplants. Your primary care physician will give a referral for these services if they are medically necessary.

Section 4. Your cost for covered services

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

Copayments

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

You pay a primary care provider copayment when you visit any primary care provider as described in Section 3, *How you get care*, or when you visit an OB/Gyn for routine care. You pay a specialist copayment when you receive care from a specialist as described in Section 3.

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

- Under the High Option Plan, you pay a \$15 copayment when you receive diagnostic and treatment services from a primary care or specialty care provider.
- Under the Standard Option Plan, you pay a \$20 copayment when you receive diagnostic and treatment services from a primary care provider and a \$30 copayment when you receive these services from a specialty care provider.

Cost-sharing

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

Deductible

We do not have a deductible.

Coinsurance

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

Example: In our Plan, you pay 50 percent of our allowance for infertility services.

Fees when you fail to make your payment

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

Fees when you miss a medical appointment

If you miss a medical appointment, we will charge you \$10, unless you notify us in advance.

Note: Affiliated physician offices and other providers and facilities may bill you an additional charge along with any unpaid copayments or coinsurance.

Your catastrophic protection out-of-pocket maximum

After your copayments and coinsurance total \$750 per person for the High Option or \$1,250 per person for the Standard Option or \$1,500 per family for the High Option or \$2,500 per family for the Standard Option or per enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurances for the following services do not count toward your catastrophic protection out-of-pocket maximum. You must continue to pay copayments and coinsurance for these services under both the High and Standard Option:

- Outpatient prescription drugs
- Contraceptive devices
- Dental services
- Orthotic and prosthetic devices
- Durable medical equipment
- The \$25 charges paid for follow-up or continuing care when you are traveling out of our service area
- Long-term physical therapy and rehabilitation
- Eyeglasses and contact lenses

- Health education services
- Self-referred chiropractic care

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

Carryover

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

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

When Government facilities bill us

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

Section 5. High and Standard Option Benefits

See page 8 for how our benefits changed this year. Pages 74 and 75 are a benefit summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6—they apply to the benefits in the following subsections. For more information about Standard and High Option benefits, contact us at 503-813-2000, or 1-800-813-2000 or at our Web site at <http://kp.org/feds>.

Kaiser Foundation Health Plan of the Northwest has been a leader in offering high quality medical, dental, vision, and wellness care to FEHB for more than 40 years. Today, the Health Plan offers two benefit plans to Federal members, the Standard and High Option plans. Both options are designed to include preventive and acute care services provided by our Plan providers, but offer different levels of benefits and services for you to choose between to best fit your health care needs. Each option offers unique features.

High Option

Our FEHB High Option provides the most comprehensive benefits. Highlights of FEHB High Option Benefits include:

- \$15 copayment for dental office visits; plus 50 percent of our allowance for restorative services including routine fillings, simple extractions, endodontics, periodontics (including follow-up cleaning visits) prosthetic devices, crowns, bridges, inlays, and oral surgery
- No copayment for adult preventive care routine exams, well-child office visits, or prenatal office visits
- \$15 copayment per visit to your primary care physician (PCP) or specialist
- \$75 copayment for emergency care in a hospital emergency department
- For up to a 30-day supply, \$15 copayment per prescription for generic drugs and \$30 copayment per prescription for brand-name drugs
- \$100 copayment per admission for inpatient hospital admissions

Standard Option

With the Standard Option your copayments and coinsurance may be higher than for the High Option, but the bi-weekly premium is lower. Highlights of FEHB Standard Option Benefits include:

- No copayment for adult preventive care routine exams, well-child office visits, or prenatal office visits
- \$20 copayment per visit to your primary care physician (PCP)
- \$30 copayment for specialty care office visits
- For up to a 30-day supply, \$20 copayment per prescription for generic drugs and \$40 copayment per prescription for brand-name drugs
- \$100 copayment for emergency care in a hospital outpatient emergency department
- \$250 copayment per admission for inpatient hospital admissions

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. Consult with your physician to determine what is appropriate for you. Services may be covered provided that established Plan physician criteria are met.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Please refer to the pre-authorization information shown in Section 3 to be sure which services and surgeries require pre-authorization.

Benefit Description	You pay	
	High Option	Standard Option
Diagnostic and treatment services		
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • In a physician’s office • Office medical consultations • Second surgical opinion • In an urgent care center • Initial examination of a newborn child covered under a Self and Family enrollment 	\$15 per office visit	\$20 per visit in a primary care department \$30 per visit in a specialty care department
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing for inpatient professional services	Nothing for inpatient professional services
<ul style="list-style-type: none"> • At home 	Nothing	Nothing
Lab, X-ray, and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG 	Nothing (See Section 5(c) for hospital charges)	\$20 per department visit (See Section 5(c) for hospital charges)

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

Benefit Description	You pay	
	High Option	Standard Option
Lab, X-ray, and other diagnostic tests (cont.)		
Special procedures: <ul style="list-style-type: none"> • CAT scans • MRI • PET scans 	\$100 per department visit (See Section 5(c) for hospital charges)	\$100 per department visit (See Section 5(c) for hospital charges)
Preventive care, adult	High Option	Standard Option
<ul style="list-style-type: none"> • Routine examinations 	Nothing	Nothing
Routine screenings, such as: <ul style="list-style-type: none"> • Total blood cholesterol • Colorectal cancer screening, including: <ul style="list-style-type: none"> - Double contrast barium enema every five years starting at age 50 - Fecal occult blood test • Routine Prostate Specific Antigen (PSA) test—one annually for men age 40 and older • Routine Pap test Notes: <ul style="list-style-type: none"> • You should consult with your physician to determine what is appropriate and medically necessary for you. • You will pay only one copayment per department visit if you receive your routine screening on the same day as your office visit. 	Nothing	\$20 per department visit
Routine screenings, such as: <ul style="list-style-type: none"> • Colorectal cancer screening, including: <ul style="list-style-type: none"> - Colonoscopy screening - every ten years starting at age 50 - Sigmoidoscopy screening - every five years starting at age 50 	\$50 per office visit	\$100 per office visit
Routine mammogram—covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five-year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years Note: In addition to routine screening, we cover mammograms when medically necessary to diagnose or treat your illness.	Nothing	\$20 per office visit

Preventive care, adult - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Preventive care, adult (cont.)		
<ul style="list-style-type: none"> • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) 	Nothing	Nothing
<ul style="list-style-type: none"> • Visits to receive injections 	\$5 per office visit	\$5 per office visit
<ul style="list-style-type: none"> • Travel-related injectable immunizations <p>Note: We cover travel-related oral immunizations under the prescription drug benefit.</p>	\$15 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams and immunizations required for:</i> <ul style="list-style-type: none"> - <i>Obtaining or continuing employment</i> - <i>Insurance</i> - <i>Attending schools</i> 	<i>All charges</i>	<i>All charges</i>
Preventive care, children	High Option	Standard Option
<ul style="list-style-type: none"> • Well-baby care charges for routine examinations, immunizations and care for ages 0-2 	Nothing	Nothing
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations, and care for ages 3-17 	Nothing	Nothing
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: <ul style="list-style-type: none"> - Eye exams to determine the need for vision correction - Ear exams to determine the need for hearing correction - Examinations done on the day of immunizations 	Nothing	Nothing
<p>Travel-related injectable immunizations</p> <p>Note: We cover travel-related oral immunizations under the prescription drug benefit. See Section 5(f) for prescription drug benefits.</p>	\$15 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams and immunizations required for:</i> <ul style="list-style-type: none"> - <i>Obtaining or continuing employment</i> - <i>Insurance</i> - <i>Attending schools or camps</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
Maternity care		
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Notes: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your 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 hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c) for hospital benefits and Section 5(b) for surgery benefits. 	<p>\$15 per office visit, except nothing for prenatal visits</p> <p>(See Section 5(c) for hospital charges)</p>	<p>\$20 per office visit, except nothing for prenatal visits</p> <p>(See Section 5(c) for hospital charges)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Routine sonograms to determine fetal age, size, or sex</i> 	<i>All charges</i>	<i>All charges</i>
Family planning		
<ul style="list-style-type: none"> • Family planning services including counseling • Voluntary sterilization (See Section 5(b), <i>Surgical procedures</i>) • Surgically implanted time-release contraceptives and intrauterine devices (IUDs) <p>Note: In addition to the office visit copayment for surgical procedures related to internally implanted time-release contraceptive drugs and contraceptive devices, we charge for the drug or device according to your prescription drug benefit. Other contraceptive drugs and diaphragms are also covered under your prescription drug benefit.</p>	<p>\$15 per office visit</p>	<p>\$20 per visit in a primary care department</p> <p>\$30 per visit in a specialty care department</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
Infertility services		
Diagnosis and treatment of involuntary infertility including artificial insemination limited to intrauterine insemination (IUI)	50% of our allowance	50% of our allowance
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
<p><i>These exclusions apply to fertile as well as infertile individuals or couples:</i></p> <ul style="list-style-type: none"> • <i>Intravaginal insemination (IVI)</i> • <i>Intracervical insemination (ICI)</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm and donor eggs and services related to their procurement and storage</i> • <i>Drugs used in the diagnosis and treatment of infertility</i> 		
Allergy care	High Option	Standard Option
• Allergy testing	\$15 per office visit	\$30 per visit in a specialty care department
• Allergy injections	\$5 per office visit	\$5 per office visit
• Allergy serum	Nothing	Nothing
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
<ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 		
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: We limit high dose chemotherapy in association with autologous bone marrow transplants to those transplants listed under Organ/Tissue Transplants in Section 5(b), <i>Surgical and anesthesia services</i>.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis—hemodialysis and peritoneal dialysis 	\$15 per office visit	\$30 per visit in a specialty care department
Note: We cover growth hormone therapy (GHT) under the Prescription Drug benefit. See Section 5(f) for growth hormone coverage.		

Treatment therapies - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Treatment therapies (cont.)		
<ul style="list-style-type: none"> Intravenous (IV)/Infusion Therapy—home IV and antibiotic therapy 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Long-term rehabilitative therapy</i> <i>Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered</i> <i>Cognitive therapy.</i> 	<i>All charges</i>	<i>All charges</i>
Physical and occupational therapies	High Option	Standard Option
<p>Benefit is limited to the greater of 20 visits or 2 months per condition for each therapy:</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 is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living <p>Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction</p>	<p>\$15 per outpatient visit</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>	<p>\$30 per outpatient visit in a specialty care department</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>
<ul style="list-style-type: none"> Multidisciplinary rehabilitation is provided for up to 60 days per condition. The 60-day limit applies to all prescribed inpatient and outpatient multidisciplinary rehabilitative services you may receive for the same condition, provided in an organized comprehensive multidisciplinary facility or program <ul style="list-style-type: none"> Outpatient multidisciplinary rehabilitation Inpatient multidisciplinary rehabilitation at hospital or skilled nursing facility when admitted from home 	<p>\$15 per day</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>	<p>\$30 per day in a specialty care department</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Long-term rehabilitative therapy</i> <i>Exercise programs</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
Speech therapy		
Benefit is limited to the greater of 20 visits or 2 months per condition for each therapy: <ul style="list-style-type: none"> • Speech therapy by speech pathologists when medically necessary 	\$15 per outpatient visit Nothing for inpatient professional services (See Section 5(c) for hospital charges)	\$30 per outpatient visit in a specialty care department Nothing for inpatient professional services (See Section 5(c) for hospital charges)
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Speech therapy that is not medically necessary such as:</i> <ul style="list-style-type: none"> - <i>Therapy for educational placement or other educational purposes</i> - <i>Therapy for tongue thrust in the absence of swallowing problems</i> 	<i>All charges</i>	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • Hearing testing to determine the need for hearing correction 	\$15 per office visit	\$30 per visit in a specialty care department
<ul style="list-style-type: none"> • Hearing aids for children under age 18, if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist <p>Note: A single hearing aid providing hearing to both ears (binaural hearing aid) is considered two hearing aids for purposes of this benefit.</p>	All charges in excess of \$1,000 for each hearing impaired ear every 36 months	All charges in excess of \$1,000 for each hearing impaired ear every 36 months
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, including testing and examinations for them, for all persons age 18 and over</i> 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • Diagnosis and treatment of diseases of the eye • Eye refractions 	\$15 per office visit	\$20 per visit in a primary care department \$30 per visit in a specialty care department
<ul style="list-style-type: none"> • Lenses, frames, industrial safety glasses, and/or medically necessary contact lenses every 24 months • Medically necessary contact lenses for: <ul style="list-style-type: none"> - Extremely high degrees of near or farsightedness 	The cost of lenses, frames, industrial safety glasses, and/or medically necessary contact lenses less \$150	The cost of lenses, frames, industrial safety glasses, and/or medically necessary contact lenses less \$150

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

Benefit Description	You pay	
	High Option	Standard Option
Vision services (testing, treatment, and supplies) (cont.)		
<ul style="list-style-type: none"> - Distorted corneas which limit the best visual acuity with glasses - Visual error of the two eyes which are greatly different in power 	The cost of lenses, frames, industrial safety glasses, and/or medically necessary contact lenses less \$150	The cost of lenses, frames, industrial safety glasses, and/or medically necessary contact lenses less \$150
<ul style="list-style-type: none"> • You may select non-medically necessary contact lenses instead of lenses, frames, and/or industrial safety glasses 	The cost of contact lenses less \$150	The cost of contact lenses less \$150
<ul style="list-style-type: none"> • Eyeglasses and contact lens(es) after cataract surgery with intraocular lens implant: <ul style="list-style-type: none"> - Medically necessary intraocular lenses - One pair of eyeglasses (regular lenses and designated frames); or - One pair of contact lenses 	Nothing	Nothing
<ul style="list-style-type: none"> • Eyeglasses and contact lens(es) after cataract surgery not involving intraocular lens implant: <ul style="list-style-type: none"> - One pair of contact lenses and/or one pair of designated frames and regular lenses if both must be worn at the same time to provide a significant improvement in visual acuity or binocular vision not obtainable with regular lenses or contact lens(es) alone 	Nothing	Nothing
<p>What you should know:</p> <p>Vision care benefits are provided to members when prescribed by Plan physicians or optometrists and provided at Plan facilities and optical departments</p> <p>Your vision care benefits for lenses, frames, industrial safety glasses, and/or medically necessary contact lenses renews every 24 months from the date you last received them</p> <p>If a significant change in correction occurs in one or both eyes within 12 months of the initial exam, we cover lenses, industrial safety lenses or medically necessary contact lenses with the new correction at these maximum values. Replacement coverage is for the original product type (contacts or eyeglasses) only</p> <p>If you have selected non-medically necessary contact lenses in lieu of lenses and frames, and/or industrial safety glasses, and a significant change in correction occurs in one or both eyes within 12 months of the initial exam, we will cover replacement of non-medically necessary contact lenses at these maximum values. Replacement coverage is for the original product type (contacts or eyeglasses) only</p>	<p>\$60 for single vision and cosmetic contact lenses;</p> <p>\$90 for multifocal lenses</p>	<p>\$60 for single vision and cosmetic contact lenses;</p> <p>\$90 for multifocal lenses</p>

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

Benefit Description	You pay	
	High Option	Standard Option
Vision services (testing, treatment, and supplies) (cont.)		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Repair or replacement of eyewear and accessories due to loss or damage</i> • <i>Contacts having no refractive value</i> • <i>Fitting and routine follow-up services for non-medically indicated contact lenses</i> • <i>Refractions for non-medically indicated contact lenses</i> • <i>Vision therapy (orthoptics or eye exercises)</i> • <i>Radial keratotomy, photorefractive keratectomy and other refractive surgery such as LASIK surgery and evaluations for these procedures</i> • <i>Visual training</i> • <i>Low-vision aids</i> 	<i>All charges</i>	<i>All charges</i>
Foot care	High Option	Standard Option
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	\$15 per office visit	\$30 per visit in a specialty care department
<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, unless medically necessary for conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained, or flat feet or bunions or spurs; and of any instability, imbalance, or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges</i>	<i>All charges</i>
Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. <p>Note: See Section 5(c) for payment information and Section 5(b) for coverage of the surgery to insert the device.</p>	Nothing	Nothing
<ul style="list-style-type: none"> • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome 	20% of our allowance	20% of our allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Orthopedic and prosthetic devices (cont.)		
Maxillofacial prosthetic devices to restore or manage head and facial structures that are defective	20% of our allowance	20% of our allowance
When prescribed by a Plan physician, we cover orthopedic and other prosthetic devices not listed above, including repairs, adjustments or replacements other than those necessitated by misuse or loss Notes: <ul style="list-style-type: none"> We cover only those standard items that are adequate to meet the medical needs of the member. Orthopedic and other prosthetic devices are provided in accordance with the Plan's DME formulary and its guidelines. 	20% of our allowance	20% of our allowance
<i>Not covered:</i> <ul style="list-style-type: none"> <i>Devices used primarily for cosmetic purposes that are not necessary to control or eliminate infection, pain, or restore functions such as speech, swallowing, or chewing</i> <i>Artificial larynxes</i> <i>Voice machines</i> <i>Artificial hearts</i> <i>Internally implanted insulin pumps</i> <i>Dentures (except High Option)</i> <i>Devices, equipment, supplies, and prosthetics related to the treatment of sexual dysfunction</i> <i>Orthotic devices including corrective shoes</i> <i>Arch supports</i> <i>Foot orthotics</i> <i>Heel pads and heel cups</i> <i>Lumbosacral supports</i> <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> 	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)		
When prescribed by a Plan physician, we cover or purchase, at our option, durable medical equipment intended to be used repeatedly and in the home. Examples of covered items include: <ul style="list-style-type: none"> Oxygen Hospital beds Wheelchairs Crutches Walkers Blood glucose monitors 	20% of our allowance	20% of our allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Durable medical equipment (DME) (cont.)		
<ul style="list-style-type: none"> Insulin pumps <p>Note: Necessary repairs, adjustments, and replacements other than those necessitated by misuse or loss are also covered</p>	20% of our allowance	20% of our allowance
<ul style="list-style-type: none"> When prescribed in conjunction with home health care that is in lieu of inpatient hospitalization 	20% of our allowance	20% of our allowance
<p>Notes:</p> <ul style="list-style-type: none"> Durable medical equipment (DME) is equipment that is prescribed by a Plan physician and is intended for repeated use, medically necessary, primarily and customarily used to serve a medical purpose, generally useful only to a person who is ill or injured, designed for prolonged use, appropriate for use in the home, and serves a specific therapeutic purpose in the treatment of an illness or injury. We cover only those standard items that are adequate to meet the medical needs of the member. DME-related supplies are provided in accordance with the Plan's DME formulary and its guidelines. DME-related supplies for the treatment of diabetes are covered under your prescription drug benefit. 		
Home health services	High Option	Standard Option
<p>If you are homebound and reside in the service area:</p> <ul style="list-style-type: none"> You may receive home health services of nurses and health aides, physical or occupational therapists, and speech and language pathologists, when prescribed by your Plan physician, who will periodically review the program for continuing appropriateness and need Services include intravenous therapy, and medications <p>Note: The services are covered only if a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home.</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> 	<i>All charges</i>	<i>All charges</i>

Home health services - continued on next page

Benefit Description	You pay	
Home health services (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Services outside our service area</i> • <i>Home health 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>All charges</i>	<i>All charges</i>
Chiropractic	High Option	Standard Option
<p>Chiropractic services up to 20 visits per calendar year</p> <ul style="list-style-type: none"> • Services include evaluation and management, musculoskeletal treatments, physical therapy modalities such as hot and cold packs, and X-rays <p>Note: You must choose the chiropractor from our list of participating chiropractors. Contact us to get the list. You may see a chiropractor without referral from your Plan physician.</p>	\$20 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Non-neuroskeletal disorders</i> • <i>Vocational rehabilitation services</i> • <i>Laboratory services; MRI or other type of advanced diagnostic radiology</i> • <i>Durable medical equipment or supplies for use in the home</i> 	<i>All charges</i>	<i>All charges</i>
Alternative treatments	High Option	Standard Option
<p>Short-term acupuncture is covered only as part of an integrated pain management program, only when standard medical therapies have been attempted and failed and only for the following clinical indications:</p> <ul style="list-style-type: none"> • Nausea for pregnancy • Nausea associated with chemotherapy • Chronic pain <p>Response to acupuncture must be evident after an initial course of treatment.</p>	\$15 per office visit	\$30 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Other alternative treatments, including:</i> <ul style="list-style-type: none"> - <i>acupuncture (except as stated above)</i> - <i>naturopathic services</i> - <i>hypnotherapy</i> - <i>biofeedback</i> 	<i>All charges</i>	<i>All charges</i>

High and Standard Option

Benefit Description	You pay	
Educational classes and programs	High Option	Standard Option
No benefit	<i>All charges</i>	<i>All charges</i>

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay	
	High Option	Standard Option
<p>Surgical procedures</p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See Section 5(a), <i>Orthopedic and prosthetic devices</i>, for coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns • Surgically implanted time-release contraceptives and intrauterine devices (IUDs) • Other implanted time-release drugs <p>Note: In addition to the office visit copayment, we charge the prescription drug copayment for the drug or device.</p>	<p>\$15 per office visit</p> <p>\$50 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>	<p>\$30 per office visit in a specialty care department</p> <p>\$100 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>

Surgical procedures - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
<p>Surgical procedures (cont.)</p> <ul style="list-style-type: none"> Surgical treatment of morbid obesity (bariatric surgery). You must: <ul style="list-style-type: none"> - be 18 years of age or older; and - have either a Body Mass Index (BMI) of 50 or greater, or a BMI of 35 up to 49.9 when a combination of the following severe or life threatening conditions are also present: sleep apnea uncontrolled with C-PAP therapy; diabetes uncontrolled with prescription medications, degenerative joint disease of weight-bearing joints, hypertension uncontrolled with prescription medications, congestive heart failure and/or cardiomyopathy, or other severe or life-threatening conditions directly related to obesity, when recommended by your Plan provider <p>Notes:</p> <ul style="list-style-type: none"> You will need to meet the above qualifications and obtain a referral from your Plan provider to our bariatric surgery program. This program may refer you to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including nutritional, psychological, medical, and social readiness for surgery. You must sign and comply with the “Severe Obesity Evaluation and Management Program Contract for Participation.” Final approval for surgical treatment will be required from the Northwest Permanente Medical Group’s designated physician. See Section 3, <i>Services requiring prior approval</i>, for more information. Insertion of internal prosthetic devices. See 5(a), <i>Orthopedic and prosthetic devices</i>, for device coverage information 	<p>\$15 per office visit</p> <p>\$50 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>	<p>\$30 per office visit in a specialty care department</p> <p>\$100 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary sterilization</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Reconstructive surgery	High Option	Standard Option

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities, cleft lip, cleft palate, birthmarks, and webbed fingers and toes • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery and reconstruction on the other breast to produce a symmetrical appearance - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$15 per office visit</p> <p>\$50 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>	<p>\$30 per office visit in a specialty care department</p> <p>\$100 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery—any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance 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	High Option	Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Medical and surgical treatment of temporomandibular joint (TMJ) disorder (non-dental); and 	<p>\$15 per office visit</p> <p>\$50 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>	<p>\$30 per office visit in a specialty care department</p> <p>\$100 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Oral and maxillofacial surgery (cont.)		
<ul style="list-style-type: none"> Other surgical procedures that do not involve the teeth or their supporting structures 	<p>\$15 per office visit</p> <p>\$50 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>	<p>\$30 per office visit in a specialty care department</p> <p>\$100 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Oral implants and transplants Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) Correction of any malocclusion not listed above Dental services associated with medical treatment such as surgery and radiation treatment, except for services related to accidental injury of teeth (See Section 5(g)) 	<i>All charges</i>	<i>All charges</i>
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ tissue transplants are limited to:</p> <ul style="list-style-type: none"> Cornea Heart Heart/Lung Intestinal transplants <ul style="list-style-type: none"> Small intestine Small intestine with the liver Small intestine with multiple organs, such as the liver, stomach, and pancreas Kidney Kidney/Pancreas Liver Lung: Single—Double Pancreas 	<p>\$15 per office visit</p> <p>\$50 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>	<p>\$30 per office visit in a specialty care department</p> <p>\$100 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the diagnosis and staging description.)</p> <ul style="list-style-type: none"> • Allogeneic (donor) bone marrow transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	<p>\$15 per office visit</p> <p>\$50 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>	<p>\$30 per visit in a specialty care department</p> <p>\$100 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogenic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors <p>Limited benefits—Autologous blood or bone marrow stem cell transplants for breast cancer and epithelial ovarian cancer may be provided in a National Cancer Institute (NCI) – or National Institutes of Health (NIH) – approved clinical trial at a Plan-designated Center of Excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols</p>	<p>\$15 per office visit</p> <p>\$50 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>	<p>\$30 per visit in a specialty care department</p> <p>\$100 for outpatient surgeries and procedures performed in an operating room</p> <p>Nothing for inpatient professional services</p> <p>(See Section 5(c) for hospital charges)</p>
<p>Notes:</p> <ul style="list-style-type: none"> • We cover related medical and hospital expenses of the donor when we cover your transplant. • Please refer to Section 5(g) Special features for information on our Centers of Excellence. 		

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<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	High Option	Standard Option
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Nothing</p> <p>(See Section 5(c) for hospital charges)</p>	<p>Nothing</p> <p>(See Section 5(c) for hospital charges)</p>

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay	
	High Option	Standard Option
<p>Inpatient hospital</p> <p>Room and board, such as:</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$100 per admission	\$250 per admission
<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 • Blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Costs associated with blood donated by you for a scheduled covered surgery <p>Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The need for anesthesia, by itself, is not such a condition.</p>	\$100 per admission	\$250 per admission
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care and care in an intermediate care facility</i> • <i>Non-covered facilities, such as nursing homes</i> 	<i>All charges</i>	<i>All charges</i>

*Inpatient hospital - continued on next page
High and Standard Section 5(c)*

Benefit Description	You pay	
	High Option	Standard Option
Inpatient hospital (cont.)		
<ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, and guest meals and beds</i> • <i>Private nursing care, except when medically necessary</i> • <i>Inpatient dental procedures</i> • <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient</i> 	<i>All charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center		
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Lab, X-ray, and other diagnostic tests • Blood and blood products • Dressings, casts, and sterile trays • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service <p>Note: Your regular prescription drug copayment will apply for prescriptions purchased at Plan pharmacies.</p>	Nothing (See Section 5(a) or 5(b) for professional charges)	Nothing (See Section 5(a) or 5(b) for professional charges)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Collection, processing, and storage of blood donated by donors designated by you or a family member</i> • <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient</i> 	<i>All charges</i>	<i>All charges</i>
Skilled nursing care benefits		
<p>Up to 100 days per calendar year when you need full-time skilled nursing care</p> <p>All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Room and board • General nursing care • Medical social services • Prescribed drugs, biologicals, supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care and care in an intermediate care facility</i> 	<i>All charges</i>	<i>All charges</i>

Skilled nursing care benefits - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Skilled nursing care benefits (cont.)		
<ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, and guest meals and beds</i> 	<i>All charges</i>	<i>All charges</i>
Hospice care		
<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: <ul style="list-style-type: none"> - in the home, when a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home, or - in a Plan-approved hospice facility if approved by the hospice interdisciplinary team. <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 patient that emphasizes supportive services, such as home care and pain and symptom control, rather than curative care. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, therapy services for purposes of safety and symptom control, physician services, palliative drugs in accord with our drug formulary guidelines, durable medical equipment (DME), and short-term inpatient care for pain control and acute and chronic symptom management. We also provide inpatient respite care, counseling and bereavement. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing (private duty nursing)</i> • <i>Homemaker services</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
Ambulance	High Option	Standard Option
<ul style="list-style-type: none"> Local licensed ambulance service when medically necessary. <p>Note: See Section 5(d) for emergency services.</p>	\$75 per trip	\$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, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider</i> 	<i>All charges</i>	<i>All charges</i>

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

If you have an emergency, call 911. When the operator answers, stay on the phone and answer all questions.

Emergencies within our service area:

Emergency care is provided at Plan hospitals 24 hours a day, seven days a week. If you have a medical emergency, go to the closest Plan hospital. If you reasonably believe you have a medical emergency condition and you cannot safely go to a Plan hospital, call 911 or go to the nearest hospital. If an ambulance comes, tell the paramedics that the person who needs help is a Kaiser Permanente member.

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.

If you are admitted to a non-Plan facility, call the Patient Transfer Coordinator from Portland at 503-571-4540. From all other areas dial 1-877-813-5993 and ask for the Patient Transfer Coordinator. You must notify the Plan as soon as is reasonably possible. If you are hospitalized in a non-Plan facility and Plan physicians believe your care can be better provided in a Plan facility, you will be transferred when medically feasible. Post stabilization care requires preauthorization.

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

Emergencies outside our service area:

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

If you need to be hospitalized, the Plan must be notified as soon as is reasonably possible. If a Plan physician believes care can be better provided in a Plan hospital, we will transfer you when medically feasible.

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local telephone book under Kaiser Permanente. These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling the Membership Services department from Portland at 503-813-2000, or from other areas call 1-800-813-2000 or our TTY number at 1-800-735-2900.

Benefit Description	You pay	
Emergency within our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at a Plan urgent center 	\$15 per office visit	\$20 per office visit
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including physicians' services 	\$75 per office visit	\$100 per office visit
<p>Notes:</p> <ul style="list-style-type: none"> We waive your emergency copayment for services provided in a licensed emergency department if you are directly admitted to a hospital as an inpatient. Your inpatient admission copayment will still apply (See Section 5(c)). Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency copayment will not be waived. 		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> 	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$15 per office visit	\$20 per office visit
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including physicians' services 	\$75 per office visit	\$100 per office visit
<p>Notes:</p> <ul style="list-style-type: none"> We waive your emergency room copayment for services provided in a licensed emergency department if you are directly admitted to the hospital as an inpatient. Your inpatient admission copayment will still apply (See Section 5(c)). Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency copayment will not be waived. See Section 5(h) for travel benefit coverage of continuing or follow-up care. 		
<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>

Benefit Description	You pay	
	High Option	Standard Option
Ambulance		
Licensed ambulance service, including air ambulance, when medically necessary. Notes: <ul style="list-style-type: none"> • See Section 5(c) for non-emergency service. • Trip means any time an ambulance is summoned on your behalf. 	\$75 per trip	\$75 per trip
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Trips we determine are not medically necessary</i> • <i>Transportation by car, taxi, bus, gurney van, wheelchair vain, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a provider or facility</i> 	<i>All charges</i>	<i>All charges</i>

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are clinically appropriate to treat your condition.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Please refer to the pre-authorization information shown in Section 3 to be sure which services and surgeries require pre-authorization.

Benefit Description	You pay	
	High Option	Standard Option
<p>Mental health and substance abuse benefits</p> <p>We cover all diagnostic and treatment services recommended by a Plan mental health or substance abuse provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs and supplies described elsewhere in this brochure.</p> <p>Notes:</p> <ul style="list-style-type: none"> • We cover the services only when we determine that the care is clinically appropriate to treat your condition, and only when you receive the care as part of a treatment plan developed by a Plan mental health or substance abuse provider. • OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment 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 disorders, mental illness, or disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Treatment services (including individual and group therapy visits) • Crisis intervention and stabilization for acute episodes • Psychological testing necessary to determine the appropriate psychiatric treatment • Medication evaluation and management 	<p>\$15 per office visit for individual therapy</p> <p>\$7 per office visit for group therapy</p>	<p>\$20 per office visit for individual therapy</p> <p>\$10 per office visit for group therapy</p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<p>Diagnosis and treatment of alcoholism and drug abuse. Services include:</p> <ul style="list-style-type: none"> • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) <p>Notes:</p> <ul style="list-style-type: none"> • You may see a Plan outpatient mental health or substance abuse provider for these services without a referral from your primary care physician. See Section 3, <i>How you get care</i>, for information about services requiring our prior approval. • Your Plan mental health or substance abuse provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you. 	<p>\$15 per office visit for individual therapy</p> <p>\$7 per office visit for group therapy</p>	<p>\$20 per office visit for individual therapy</p> <p>\$10 per office visit for group therapy</p>
<ul style="list-style-type: none"> • Inpatient psychiatric or substance abuse care • Residential treatment <p>Note: All inpatient admissions and hospital alternative services treatment programs require pre-approval by a Plan mental health or substance abuse physician.</p>	<p>\$100 per admission</p>	<p>\$250 per admission</p>
<ul style="list-style-type: none"> • Intensive outpatient psychiatric treatment programs <p>Note: These services must be pre-approved by a Plan mental health or substance abuse physician.</p>	<p>\$15 per day</p>	<p>\$20 per day</p>
<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, 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> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Services rendered or billed by a school or a member of its staff</i> • <i>Services provided under a federal, state, or local government program</i> • <i>Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms</i> 	<i>All charges</i>	<i>All charges</i>

Limitation

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

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A Plan or referral physician, your primary care provider, or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan medical office pharmacy, or through our mail order program.
- **You may also obtain your prescriptions online,** using the member section of our Web site, <http://kp.org/feds>. This site requires online registration. You can choose to have your prescriptions mailed to your home or to a Plan medical office pharmacy for you to pick up. Online prescription orders must be paid for in advance, by a credit card. Members may receive up to a 90-day supply of maintenance medications for two copayments, when purchased through the mail order/online prescription benefit.
- **We use a formulary.** A formulary is a listing of preferred pharmaceutical substances and formulas. 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. These preferred drugs are included on our formulary. If your physician feels that a non-formulary drug is the most appropriate therapy to meet your individual medical needs, your physician may request an exception. Criteria for exceptions include:
 1. You are intolerant of formulary alternatives.
 2. You have experienced treatment failure with formulary alternatives.
 3. You are allergic to formulary alternatives.
 4. Your condition meets medication-specific criteria. If applicable, the pharmacy can provide you with a copy of the criteria upon request.
- **These are the dispensing limitations.** We provide up to a 30-day supply for one copayment. Maintenance medications may be obtained for up to a 90-day supply for two copayments when ordered through our mail order/online program. Drugs requiring special handling, which may include professional administration or observation, or refrigeration are not provided through mail order. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call 503-813-2000 (Portland area) or 1-800-813-2000 (all other areas).
- **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.
- **When you do have to file a claim.** When you receive drugs from a Plan pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy.

Benefit Description	You pay	
Covered medications and supplies	High Option	Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs for which a prescription is required by law • Insulin • Glucose test strips • Disposable needles and syringes for administration of covered prescribed medications <p>Note: The cost of any needles and syringes (not for insulin) may be less than your copayment. If this is the case, you are required to pay the cost of the needles and syringes.</p> <ul style="list-style-type: none"> • Smoking cessation drugs and medication, including prescribed nicotine gum and patches, when used in conjunction with smoking cessation programs • Chemotherapy • Drugs for foreign travel • Certain over-the-counter medications prescribed by a Plan physician and listed on the Plan’s formulary as the most appropriate treatment for a particular condition <p>Notes: The brand name drug copayment applies to compounded products and to single source generic drugs.</p> <ul style="list-style-type: none"> • A compounded drug is one in which two or more drugs or pharmaceutical agents are combined together to meet the requirements of a prescription. • A single source generic drug is a generic drug available in the United States only from a single manufacturer and that is not listed as generic in the then-current commercially available drug database (s) to which Plan subscribes. • Contraceptive drugs and devices: <ul style="list-style-type: none"> - Diaphragms and cervical caps - Intrauterine devices (IUDs) - Injectable contraceptive drugs - Implanted time-release contraceptive drug - Oral contraceptive drugs • Other implanted time-release drugs 	<p>\$15 per prescription or refill for generic drugs or devices</p> <p>\$30 per prescription or refill for brand-name drugs or devices</p>	<p>\$20 per prescription or refill for generic drugs or devices</p> <p>\$40 per prescription or refill for brand-name drugs or devices</p>
<ul style="list-style-type: none"> • Drugs to treat sexual dysfunction 	<p>50% of our allowance</p>	<p>50% of our allowance</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Covered medications and supplies (cont.)		
Note: These drugs have dispensing limitations. Contact the Plan for details.	50% of our allowance	50% of our allowance
<ul style="list-style-type: none"> • Diabetic supplies such as external insulin pumps, infusion devices, lancets, glucose monitors, and diabetic foot care appliances 	20% of our allowance	20% of our allowance
<ul style="list-style-type: none"> • Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU) • Immunosuppressive drugs required after a transplant • Intravenous fluids and medication for home 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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 obtained at a non-Plan pharmacy except for out-of-area emergencies</i> • <i>Vitamins and nutritional supplements that can be purchased without a prescription</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs used in the diagnosis and treatment of infertility</i> • <i>Drugs related to non-covered services</i> • <i>Drugs used for weight management</i> • <i>Any packaging other than the dispensing pharmacy's standard packaging</i> • <i>Replacement of lost, stolen, or damaged drugs and accessories</i> 	<i>All charges</i>	<i>All charges</i>

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- For High Option members with dental coverage, Plan dentists must provide or arrange your care except as described under the Accidental injury to teeth benefit below.
- We cover hospitalization for dental procedures at a Plan hospital we designate subject to pre-authorization 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 except as described below.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Note: You will have to pay \$10 for each missed appointment, unless you notify the dental office in advance.

Benefit Description	You Pay	
	High Option	Standard Option
Accidental injury benefit		
We cover services to promptly repair (but not replace) a sound, natural tooth, if: <ul style="list-style-type: none"> • Damage is due to an accidental injury from trauma to the mouth from violent contact with an external object, • The tooth has not been restored previously, except in a proper manner, and • The tooth has not been weakened by decay, periodontal disease, or other existing dental pathology <p>Note: Services will be covered only when provided within 72 hours following the accidental injury.</p>	All charges after \$500 per accidental injury The maximum benefit amount we will pay is \$500 per accidental injury	All charges after \$500 per accidental injury The maximum benefit amount we will pay is \$500 per accidental injury
<i>Not covered:</i> <i>Services for conditions caused by an accidental injury occurring before your eligibility date</i>	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You Pay	
	High Option	Standard Option
<p>Members who have elected the High Option Plan will receive a comprehensive range of dental services as described below. All services must be prescribed by Plan dentists and provided at Plan dental offices</p> <p>Note: These benefits are not covered under the Standard Option. Members covered under Standard Option may use Kaiser Permanente Dental facilities only as appointment access permits.</p>	See below	No benefit
<p>Diagnostic services and preventive care including:</p> <ul style="list-style-type: none"> • Routine oral examinations • X-rays • Routine teeth cleaning and topical application of fluoride when prescribed by a Plan dentist, but not more than two visits in any twelve-month period • Prescribed space maintainers and habit appliances 	\$15 per office visit	<i>All charges</i>
<p>Basic restorative services including basic restorative services resulting from accidental injury as follows:</p> <ul style="list-style-type: none"> • Amalgam (silver) restorations in posterior teeth and anterior teeth • Synthetic (plastic, resin, and glass ionomer) restorations in all primary teeth, anterior teeth and one-surface restorations of posterior permanent teeth • Stainless steel or plastic crowns when amalgam or synthetic restorative materials are not professionally appropriate • If a member requests a procedure or material in excess of that recommended by a Plan dentist, the desired procedure or material may be provided upon payment of charges that reflect the additional value of providing the procedure or material, only if a Plan dentist agrees to perform the service 	\$15 per office visit plus 50% of our allowance	<i>All charges</i>
<p>Major restorative services as follows:</p> <ul style="list-style-type: none"> • Placement of crowns, inlays, bridge pontics, or other cast metal restoration when prescribed by a Plan dentist • If a member requests a procedure or material in excess of that recommended by a Plan dentist, the desired procedure or material may be provided upon payment of charges that reflect the additional value of providing the procedure or material, only if a Plan dentist agrees to perform the service <p>Note: We do not cover repair or replacement of existing cast crowns, inlays, bridge pontics, or other cast metal restorations less than five years after the date of the most recent placement or replacement.</p>	\$15 per office visit plus 50% of our allowance	<i>All charges</i>

Dental benefits - continued on next page

Benefit Description	You Pay	
	High Option	Standard Option
Dental benefits (cont.) Oral surgery services as follows: <ul style="list-style-type: none"> • Diagnosis, evaluation, consultation, and treatment for removal of teeth (including local anesthesia) • Minor surgical preparation of mouth for insertion of dentures • Surgical treatment normally performed by a dentist for minor pathological conditions 	\$15 per office visit plus 50% of our allowance	<i>All charges</i>
Periodontal services as follows: <ul style="list-style-type: none"> • Diagnosis, evaluation, consultation, and treatment for diseases of tissues supporting the teeth including all follow-up cleaning visits 	\$15 per office visit plus 50% of our allowance	<i>All charges</i>
Endodontic services as follows: <ul style="list-style-type: none"> • Diagnosis, evaluation, consultation, and treatment for root canal therapy 	\$15 per office visit plus 50% of our allowance	<i>All charges</i>
Removable prosthetic appliances and services as follows: <ul style="list-style-type: none"> • Diagnosis, evaluation, consultation, and treatment for removable prosthetic appliances, including full or partial dentures, relines, and rebases <p>Note: If the removable appliance cannot be satisfactorily repaired or adjusted, then we cover a new prosthetic appliance as long as the existing appliance is more than 5 years old.</p>	\$15 per office visit plus 50% of our allowance	<i>All charges</i>
Emergency or urgent care *Notes: <ul style="list-style-type: none"> • This copayment applies only to emergency or urgent dental care received from a Plan dentist at Plan dental offices. • All other applicable copayments and coinsurance apply. 	*\$25 per office visit	<i>All charges</i>
Out-of-area emergency care Note: The Plan pays up to \$100 for emergency care for relief of pain, acute infection, or hemorrhage, or necessary treatment (including local anesthesia and pre-medication) due to injury.	All charges exceeding \$100	<i>All charges</i>
Prescription drugs	See Section 5(f) for prescription drug benefits	See Section 5(f) for prescription drug benefits
Nitrous oxide: <ul style="list-style-type: none"> • Adults and children over 12 years of age 	\$15 per occurrence	<i>All charges</i>
<ul style="list-style-type: none"> • Children 12 years of age and under 	Nothing	<i>All charges</i>
Nightguards	10% of our allowance	<i>All charges</i>
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>

Dental benefits - continued on next page

Benefit Description	You Pay	
	High Option	Standard Option
<p>Dental benefits (cont.)</p> <ul style="list-style-type: none"> • <i>Orthodontics</i> • <i>Dental treatment for problems of the jaw joint, including temporomandibular joint syndrome/ craniomandibular disorders; or other conditions of the joint linking the jaw bone and skull, and of the complex of muscles, nerves, and other tissues related to that joint</i> • <i>Dental implants, including bone augmentation and the fixed or removable prosthetic devices attached to or covering the implants; and all services and materials relating to the placement or removal of implants including, but not limited to, diagnostic consultations, impressions, oral surgery, and removal of implants for cleaning; and dental services related to post-operative conditions or complications arising from implants</i> • <i>Restorative or reconstructive services for congenital or developmental malformations</i> • <i>Full mouth reconstructions. This includes appliances, restoration, and procedures needed to alter vertical dimension or occlusion, or in conjunction with alteration of vertical dimension or occlusion or for the purpose of splinting teeth or correcting attrition or abrasion.</i> • <i>Cosmetic dental services, including replacement of cosmetic dental restoration</i> • <i>Restoration replacement. Clinically acceptable restorations or material will not be removed or replaced with alternative materials unless a pathological condition of the teeth exists</i> • <i>IV sedation</i> • <i>Genetic testing</i> • <i>Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns, which have not been placed by a Kaiser Permanente dentist</i> • <i>Replacement of any permanent removable appliances with new permanent removable or fixed prosthetic appliances within five years of the date the member receives the appliance regardless of where the appliance was obtained</i> • <i>Prosthetics following extraction of restorable teeth when the member has elected to extract a restorable tooth/teeth (including extractions in lieu of root canal therapy) for non-dentally necessary reasons</i> • <i>Replacement of any nightguards within five years of the date the member receives the appliance even if prescribed by a dentist outside the Plan</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Dental benefits - continued on next page

Benefit Description	You Pay	
Dental benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Replacement of any temporary removable appliance due to loss, theft, or damage beyond repair with a new temporary removable appliance within five years of the date the member received the appliance, even if provided by a non-Plan dentist 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5(h). Special features

Feature	Description
24 hour advice line	For any of your health concerns, 24 hours a day, 7 days a week, you may call from Portland at 503-813-2000, or from other areas call 1-800-813-2000 or our TTY number at 1-800-735-2900, and talk with a registered nurse who can help assess medical symptoms and provide advice over the phone, when medically appropriate.
Centers of Excellence	<p>The Centers of Excellence program began in Fall 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted “Centers of Excellence” for certain specialized medical procedures.</p> <p>We have developed a nationally contracted network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.</p>
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other treatments as a less costly alternative benefit. • We review alternative treatments on an ongoing basis. • By approving an alternative treatment, we cannot guarantee you will get it in the future. • The decision to offer an alternative treatment is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative treatments is not subject to OPM review under the disputed claims process.
Services for the deaf, hard of hearing or speech impaired	We provide a TTY/text telephone number at: 1-800-735-2900. Sign language services are also available.
Services from other Kaiser Permanente or allied plans	<p>When you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered services, copayments and coinsurance described in this FEHB brochure. The 90-day limit on visiting member care does not apply to a dependent child who attends an accredited college or accredited vocational school.</p> <p>Please call Membership Services toll-free at 1-800-813-2000, to receive more information about visiting member care, including facility locations in other service areas. Service areas and facilities where you may obtain visiting member care may change at any time.</p>
Student coverage outside the service area	<p>We provide a limited benefit to eligible dependents who are full time registered college students (at least 12 credit hours per semester) attending a recognized accredited institution outside Kaiser Permanente’s service areas and within the United States. These benefits are in addition to your emergency and travel benefits.</p> <ul style="list-style-type: none"> • Your dependent is covered for routine, continuing, and follow-up medical care. • You pay 20% of the usual and customary charges. • Your benefit is limited to \$1,200 each calendar year. • You must certify your dependent’s student status annually.

Feature - continued on next page

Feature	Description
Feature (cont.)	<ul style="list-style-type: none"> • For more information about this benefit, call 503-813-2000 (Portland area) or 1-800-813-2000 (all other areas). • File claims as shown in Section 7. <p><i>The following are not included in your out-of-area student coverage benefit:</i></p> <ul style="list-style-type: none"> • <i>Dental Services</i> • <i>Transplants and transplant follow-up care</i> • <i>Services provided outside the United States</i>
Travel benefit	<p>Kaiser Permanente’s travel benefit for Federal employees provides you with outpatient follow-up and/or continuing medical care when you are temporarily (for example, on a temporary work assignment or attending school) outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. This benefit is in addition to your emergency services/accident and student coverage outside the service area 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. <p>You pay \$25 for each follow-up or continuing care office visit. This amount will be deducted from the reimbursement we make to you or to the provider. We limit our payment for this travel benefit to no more than \$1,200 each calendar year. For more information about this benefit call our Membership Services Department at 1-800-813-2000. Our TTY is 1-800-735-2900. File claims as shown in Section 7.</p> <p><i>The following are a few examples of services not included in your travel benefits coverage:</i></p> <ul style="list-style-type: none"> • <i>Non-emergency hospitalization</i> • <i>Infertility treatments</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> • <i>Transplants</i> • <i>Durable Medical Equipment (DME)</i> • <i>Prescription drugs</i> • <i>Home health services</i>

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all complaints must follow the Plan's guidelines. For additional information contact us, from Portland, call 503-813-2000, or from other areas call 1-800-813-2000 or call our TTY number at 1-800-735-2900.

Kaiser Permanente offers a wide range of services to help you achieve and maintain good health. Here are some ways we can support you in making healthier choices.

Talk with a health consultant

If you're a member who is thinking about losing weight, quitting tobacco, or in some other way improving your health, a brief chat with a consultant in our Health Education Services department can help. From Portland, call 503-286-6816 and choose option 2. From all other areas, call 1-866-301-3866 and choose option 2.

Complementary care discounts

All Kaiser Permanente members are now eligible for special discounts on health club memberships and certain kinds of complementary care. These include acupuncture, chiropractic care, massage therapy, and naturopathic care. Before you schedule an appointment or join a health club, be sure to ask about the provider's or club's specific discount (discounts vary). If you want chiropractic care, use your FEHB chiropractic benefit first.

Visit kp.org/specialdiscounts/nw for a list of participating clubs and Complementary Healthcare Plans providers. Or call Membership Services to learn more. From Portland, call 503-813-2000. From all other areas, call 1-800-813-2000.

Classes

Through our health education classes, you can learn tools and skills to help you have a safer pregnancy, kick the tobacco habit, improve personal and family relationships, better manage weight or chronic conditions such as diabetes—and much more. For more information, pick up a *Health Living* catalog at any Kaiser Permanente facility. Or call 503-286-6816 from Portland and choose option 1. From all other areas, call 1-866-301-3866 and choose option 1.

Self-care options

We also offer services to help you take care of yourself and your loved ones.

- **kp.org** Kaiser Permanente's Web site provides information and services 24 hours a day. For example, you can search the health and drug encyclopedias. If you register on the site, you can e-mail an advice nurse or pharmacist, refill prescriptions, and more.
- **Healthphone: Call 1-800-332-7563 (for TTY call 1-800-777-9059)** This free and confidential 24-hour service provides prerecorded health information in English and Spanish. Call and listen to messages on more than 200 topics.
- **Kaiser Permanente Healthwise Handbook** This self-care guide has information on more than 180 health topics. It is free at any Membership Services desk or Health Resource Center.

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan physician determines it is medically necessary, to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- When a service is not covered, all services, drugs or supplies related to the non-covered service are excluded from coverage, except services we would otherwise cover to treat complications of the non-covered service.
- Care by non-Plan providers except for authorized referrals, emergencies, travel benefit, services from other Kaiser Permanente plans, or student coverage outside the service area (see Emergency services/accidents and Special features);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services required for (a) obtaining or maintaining employment or participation in employee programs or (b) insurance or governmental licensing; 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 fill your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us from Portland at 503-813-2000, or from other areas call 1-800-813-2000 or our TTY number at 1-800-735-2900.

When you must file a claim—such as for services you received outside of the Plan’s service area—please complete the *Non-Plan Care Information* form and submit it with the CMS-1500 or a claim form that includes the information shown below. These forms may be obtained by calling us from Portland at 503-813-2000, or from other areas call 1-800-813-2000 or our TTY number at 1-800-735-2900. 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:

Claims Administration
Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, Oregon 97232-2099

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies—including a request for preauthorization/prior approval required by Section 3.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, Oregon 97232-2099; 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. <p>You may request a copy of the complete medical criteria used if you or your provider's request for pre-authorization of treatment was denied.</p>
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 20415-2630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;Copies of all letters you sent to us about the claim;Copies of all letters we sent to you about the claim; andYour daytime phone number and the best time to call.

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

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

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

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

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us from Portland at 503-813-2000, or from other areas call 1-800-813-2000 or our TTY number at 1-800-735-2900 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 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact **1-800-MEDICARE** for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You may enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan, Kaiser Permanente Senior Advantage. Please review the information on Medicare Advantage plans on page 61.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

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

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

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

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

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

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

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

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

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at **1-800-MEDICARE (1-800-633-4227)** or at www.medicare.gov.

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

- **Medicare Advantage (Part C)**

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

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

This Plan and our Medicare Advantage plan: We offer a Medicare Advantage plan known as Kaiser Permanente Senior Advantage at no additional cost to our members eligible for Medicare benefits including Part D, as well as lower copayments and coinsurance at no cost to you. If you have already enrolled and would like to understand your additional benefits in more detail, please refer to your Medicare Annual Notice of Change (ANOC) If you are considering enrollment in our Senior Advantage plan, please call Membership Services from Portland at 1-877-221-8221, 8 a.m. to 8 p.m., 7 days a week, or our TTY number at 1-800-735-2900.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments 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.

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

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

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

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

Primary payer chart begins on next page.

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting, and taking medicine. (2) Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Custodial care that lasts 90 days or more is sometimes known as long-term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.
Experimental or investigational services	<p>We do not cover a service, supply, item or drug that we consider experimental. We consider a service, supply, item or drug to be experimental when the service, supply, item or drug:</p> <ol style="list-style-type: none">(1) has not been approved by the FDA; or(2) is the subject of a new drug or new device application on file with the FDA; or(3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or(4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or(5) is subject to the approval or review of an Institutional Review Board; or(6) requires an informed consent that describes the service as experimental or investigational. <p>We carefully evaluate whether a particular therapy is safe and effective or offers a reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental literature.</p>
Group health coverage	Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Health care coverage purchased through membership in an organization is also "group health coverage."

Medically necessary

All benefits need to be medically necessary in order for them to be covered benefits. Generally, if your Plan physician provides the service in accord with the terms of this brochure, it will be considered medically necessary. However, some services are reviewed in advance of your receiving them to determine if they are medically necessary. When we review a service to determine if it is medically necessary, a Plan physician will evaluate what would happen to you if you do not receive the service. If not receiving the service would adversely affect your health, it will be considered medically necessary. The services must be a medically appropriate course of treatment for your condition. If they are not medically necessary, we will not cover the services. In case of emergency services, the services that you received will be evaluated to determine if they were medically necessary.

Our allowance

The amount we use to determine your coinsurance. When you receive services or supplies from Plan providers, it is the amount that we set for the services or supplies if we were to charge for them. When you receive services from non-Plan providers, it is either the amount that we have negotiated with the non-Plan Provider, or if we do not have a negotiated amount, the amount that we believe is usual and customary for the service or supply, compared to the billed charges. Our allowance is based upon the reasonableness of the billed charges. If the billed 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 the Northwest.

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 that 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 <http://www.opm.gov/insure/health> for enrollment information as well as:

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

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

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

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

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

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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

- **Children's Equity Act**

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

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

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

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

• **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2008 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2007 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

• **When you retire**

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

When you lose benefits

• **When FEHB coverage ends**

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

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

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

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

- **Upon divorce** If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse’s enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse’s employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM’s Web site, <http://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 job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, *the Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from <http://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. Conversion to an individual dental plan is not available.

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 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 have information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

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

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

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

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

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. **Annuitants are not eligible to enroll.**

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

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

Where can I get more information about FSAFEDS?

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

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

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

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

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Summary of benefits for the High Option of the Kaiser Foundation Health Plan of the Northwest - 2008

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	\$15 per office visit	17
Services provided by a hospital:		
• Inpatient	\$100 per admission	36
• Outpatient	Various copayments based on procedure rendered	37
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 drugs	\$15 per prescription or refill for generic drugs (30 day supply)	47
• Brand-name drugs	\$30 per prescription or refill for brand-name drugs (30 day supply)	47
Dental care:	Various copayments based on procedure rendered	49
Vision care:	Refractions; \$15 per office visit	23
Special features: Flexible benefits option; 24 hour advice line; Services for deaf, hard of hearing or speech impaired; Centers of Excellence; Travel benefit; Services from other Kaiser Permanente or allied plans; Student coverage outside the service area		54
Protection against catastrophic costs: (your catastrophic protection out-of-pocket maximum)	Nothing after \$750/Self Only or \$1,500/Family enrollment per year Some costs do not count toward this protection	12

Summary of benefits for the Standard Option of the Kaiser Foundation Health Plan of the Northwest - 2008

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

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	\$20 per visit in a primary care department. \$30 per visit in a specialty care department	17
Services provided by a hospital:		
<ul style="list-style-type: none"> • Inpatient 	\$250 per admission	36
<ul style="list-style-type: none"> • Outpatient 	Various copayments based on procedure rendered	37
Emergency benefits:		
<ul style="list-style-type: none"> • In-area 	\$75 per visit	41
<ul style="list-style-type: none"> • Out-of-area 	\$75 per visit	41
Mental health and substance abuse treatment:		
	Regular cost sharing	43
Prescription drugs:		
<ul style="list-style-type: none"> • Generic drugs 	\$20 per prescription or refill for generic drugs (30 day supply)	47
<ul style="list-style-type: none"> • Brand-name drugs 	\$40 per prescription or refill for brand-name drugs (30 day supply)	47
Dental care:		
	No current benefit.	N/A
Vision care:		
	Refractions; \$20 per visit in a primary care department. \$30 per visit in a specialty care department	23
Special features: Flexible benefits option; 24 hour advice line; Services for deaf, hard of hearing or speech impaired; Centers of Excellence; Travel benefit; Services from other Kaiser Permanente or allied plans; Student coverage outside the service area		
Protection against catastrophic costs: (your catastrophic protection out-of-pocket maximum)		
	Nothing after \$1,250/Self Only or \$2,500/Family enrollment per year Some costs do not count toward this protection	12

Notes

Notes

2008 Rate Information for Kaiser Foundation Health Plan of the Northwest

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

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

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

For further assistance, Postal Service employees should call:

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

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	571	\$145.04	\$72.84	\$314.25	\$157.82	\$48.66	\$46.65
High Option Self and Family	572	\$329.30	\$171.22	\$713.48	\$370.98	\$116.34	\$111.76
Standard Option Self Only	574	\$132.71	\$44.23	\$287.53	\$95.84	\$22.12	\$19.91
Standard Option Self and Family	575	\$304.85	\$101.61	\$660.50	\$220.16	\$50.81	\$45.73