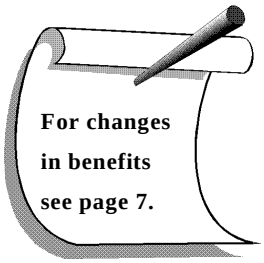
KPS Health Plans 2001

http://www.kpshealthplans.com

A Prepaid Comprehensive Medical Plan



Serving: Clallam, Kitsap, Mason, Jefferson and Thurston Counties in Northwestern Washington

Enrollment in this Plan is limited; see page 5 for requirements.

Enrollment codes for this Plan:

High Option
VT1 Self Only
VT2 Self and Family

Standard Option
VT4 Self Only
VT5 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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FEHB
Federal Employees
Health Benefits Program

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Table of Contents

Introduction

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

This brochure describes the benefits of KPS Health Plans under our contract (CS 1767) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means KPS Health Plans.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

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.

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

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

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

Comprehensive Individual-practice Prepaid Medical Plans

This Plan is a Comprehensive Individual-practice Prepaid Medical Plan. This means that we offer health services in whole or substantial part on a prepaid basis, with professional services provided by individual physicians who agree, under certain conditions approved by OPM, to accept the payments provided by the Plan and the members' cost-sharing amounts as full payment for covered services.

How We Pay Providers

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

The Plan emphasizes comprehensive medical and surgical care in Plan doctors' offices and hospitals. A Plan doctor is a Medical Doctor (MD) or Doctor of Osteopathy (DO) participating with KPS, and includes doctors participating in the KPS NorthwestOne and MultiPlan networks. A Plan dentist is a participating dentist with KPS.

For the purposes of a dependent child or member on temporary duty assignment residing outside the state of Washington, a Plan doctor or Plan dentist is a MultiPlan provider. If a MultiPlan provider is not available in the dependent's or member's temporary county of residence, then they may see any doctor or dentist practicing within the temporary county of residence at no penalty *(*See *What is this Plan's Service Area?)*

The Plan arranges with doctors (311 primary care physicians and 415 specialists) and hospitals (4), and makes referrals to nonparticipating doctors, to provide medical care for both the prevention of disease and the treatment of serious illness.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you.

If you want more information about us, call 360/478-6796 or toll free 1-800/552-7114, or write to P.O. Box 339, Bremerton, Washington 98337. You may also contact us by fax at 360/415-6514 or visit our website at http://www.kpshealthplans.com.

Service Area

To enroll in this Plan, you must live in our service area. This is where our providers practice. Our service area covers the counties of Clallam, Jefferson, Kitsap, Mason, and Thurston in Northwest Washington.

Ordinarily, you must get your care from providers who contract with us. If you receive care from non-Plan providers outside our service area, we will pay only for emergency care. We will not pay for any other health care services. Exception: eligible dependent children away at school and members on temporary duty assignment outside our service area may receive benefits for other than emergency care when arrangements are made with the Plan.

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, you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas.

If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our Plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling Customer Service at 360/478-6796 or toll free (in Washington State) 1-800/552-7114, **or** checking our website http://www.kpshealthplans.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- On the High Option, your share of the non-Postal premium will increase by 10.2% for Self only or 8.4% for Self and Family.
- On the Standard Option, your share of the non-Postal premium will increase by 45.1% for Self only or 33.4% for Self and Family.
- The exclusion for room and board under your short-term rehabilitation benefit has been removed. These charges will be covered when medically necessary.
- We have clarified covered benefits to show that both panorex and full-mouth X-rays are covered under the dental benefit.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 360/478-6796.

Where you get covered care

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

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, and internists) with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Service Department at 360/478-6796 or toll free (in Washington State) 1-800/552-7114. You can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a **specific** provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. This information is also on our website http://www.kpshealthplans.com.

What you must do

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

If, in the opinion of the Plan's medical director, your utilization of covered benefits appears to be excessive for proper medical care, you may be required to designate a Plan doctor of your choice who will arrange for coordination of your medical care and for referral to other providers. It is the responsibility of your doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization.

- **Primary care**

Your primary care physician can be any physician you choose (generally a family practitioner, internist or pediatrician). Your primary care physician will provide most of your health care or give you a referral to see a specialist.

If your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, a woman may see her Plan women's health professional for her annual routine examination without 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 and the specialist 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, and will obtain any necessary Plan authorization.

- 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 Plan; or
  - reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 360/478-6796. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process pre-authorization or pre-certification. Your physician must obtain pre-authorization for the following services: inpatient hospitalization, organ transplants, home health services, skilled nursing facility confinements, and sleep disorders. This list is not a complete list of services requiring pre-authorization. You should review Section 5 for additional information regarding pre-authorization.

Help Us Control Costs

- **Outpatient Surgery:**

Hospitalization is no longer necessary for many surgical and diagnostic procedures. These procedures can be performed safely and less expensively on an outpatient basis without sacrificing quality of care.

Listed elective surgeries and diagnostic procedures must be performed in a hospital outpatient unit, surgical center, or Plan doctor's office. These facilities are more convenient than a hospital, because surgery can be scheduled easily and quickly, and the patient can return home sooner. The cost of surgery is reduced because hospital room and board charges are eliminated.

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

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

The following procedures must be performed on an outpatient basis:

- Biopsy procedures
- Breast surgery (minor) (However, anyone who undergoes a mastectomy may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure)
- Diagnostic examination with scopes
- Dilation and curettage (D & C)
- Ear surgery (minor)
- Facial reconstruction surgery
- Tonsillectomy and adenoidectomy
- Hemorrhoid surgery
- Inguinal hernia surgery
- Knee surgery
- Nose surgery
- Removal of bunions, nails, hammertoes, etc.
- Removal of cataracts
- Removal of cysts, ganglions, and lesions
- Sterilization procedures
- Tendon, bone, and joint surgery of the hand and foot.

- **Pre-Admission Testing:** Pre-admission testing requires that necessary routine diagnostic tests be performed on an outpatient basis before you are hospitalized for elective non-emergency care. These must be performed within three days of the scheduled admission. Failure to obtain testing prior to admission will result in a 20% reduction of benefits for the testing charges. Pre-admission testing is less expensive when done on an out-patient basis and is usually more convenient.

  When inpatient hospitalization is recommended for you, ask your Plan doctor to schedule diagnostic tests on an outpatient basis within three days of admission. Pre-admission certification provides advanced confirmation for benefits from the Plan before you are admitted to a hospital or skilled nursing facility.

- **Pre-Admission Certification:** Pre-admission certification authorizes inpatient hospital benefits and is valid for six months. Approval for each admission or re-admission is required. The Plan will provide coverage only for the number of hospital days that are medically necessary and appropriate for your condition. If your hospital stay is extended due to complications, your Plan doctor must obtain benefit authorization for the extension.

  After your Plan doctor notifies you that hospitalization or skilled nursing care is necessary, ask your Plan doctor to obtain pre-admission certification. You and your Plan doctor must request pre-admission certification before hospitalization. This is a feature that allows you to know, prior to hospitalization, which services are considered medically necessary and eligible for payment under this Plan. If the hospitalization and treatment is not pre-certified, the admitting physician's fees will be reduced by 20% and benefits for the hospital stay will be reduced by $500.

  Written confirmation of the approved admission will be sent to you by the Plan once certification is obtained. If an emergency admission occurs, have your attending physician and the hospital contact the Plan within 48 hours of admission, or as soon as reasonably possible, to complete the certification process.

Section 4. Your costs for covered services

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

- **Copayments**

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

Example: On the High Option Plan, when you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay $200 per admission.

- **Deductible**

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

- The calendar year deductible is $0 per person under High Option and $100 per person under Standard Option. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $0 under High Option and $200 under Standard Option. This deductible is waived for accidental injuries on the Standard Option.

- We also have separate deductibles for Prescription Drugs under the High Option of $600 per family member.

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

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

- **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance doesn't begin until you meet your deductible. With the Standard Option you have a coinsurance of 20% for most services.

Example: In our Plan, you pay 50% of our allowance for infertility services, transplant services over $100,000, smoking cessation services, sleep disorders and treatment of morbid obesity.

Your out-of-pocket maximum for deductibles, coinsurance, and copayments

High Option – After your hospital copayments total $600 per family member you do not have to pay any more inpatient hospital copayments.

Standard Option - After your coinsurance totals $2,000 per person or $2,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services:

- Prescription drugs
- Dental services
- Services of non-Plan providers
- Transplant costs in excess of $100,000
- Diagnosis and treatment of infertility
- Smoking cessation services
- Surgical treatment of morbid obesity
- Diagnosis and treatment of sleep disorders

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

Section 5. Benefits – OVERVIEW

(See page 7 for how our benefits changed this year and page 59 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 360/478-6796 or toll free (in Washington State) 1-800/552-7114 or at our website at http://www.kpshealthplans.com.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- For the Standard Option - The calendar year deductible is $100 per person ($200 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- For High Option there is no deductible for these services
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…	
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.		
Diagnostic and treatment services	**You pay – Standard Option**	**You pay - High Option**
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion	20%	$10 per office visit (No deductible)
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	20%	Nothing (No deductible)
At home	20%	$15 per visit (No deductible)
Not covered: *Non-surgical treatment of morbid obesity* *Treatment of impotence Unless determined by the Plan to be medically necessary)* *Hearing aids*	*All charges.*	*All charges*

Lab, X-ray and other diagnostic tests	You pay – Standard Option	You pay - High Option
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	20%	Nothing (No deductible)
Preventive care, adult		
Routine screenings, such as: CompleteBlood Count – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal cancer screening, including •• Fecal occult blood test	20%	Nothing (No deductible)
•• Sigmoidoscopy, screening – every five years starting at age 50	20%	Nothing (No deductible)
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	20%	Nothing (No deductible)
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	20%	Nothing (No deductible)
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 49, one every one or two calendar years • From age 50 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years Note: In addition to routine mammograms, mammograms are covered when prescribed by the doctor as necessary to diagnosis or treat your illness.	20%	Nothing (No deductible)

Preventive care, adult -- Continued on next page

Preventive care, adult *(Continued)*	**You pay - Standard Option**	**You pay – High Option**
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing (No deductible)	Nothing (No deductible)
Preventive care, children		
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing (No deductible)	Nothing (No deductible)
• Examinations, such as: ••Eye exams through age 17 to determine the need for vision correction. ••Ear exams through age 17 to determine the need for hearing correction ••Examinations done on the day of immunizations (through age 22)	20%	$10 per office visit (No deductible)
• Well-child care charges for routine examinations, immunizations and care (through age 22)	Nothing (No deductible)	Nothing (No deductible)

Maternity care	You pay – Standard Option	You pay – High Option
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to pre-certify your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See *Hospital benefits* (Section 5c) and *Surgery benefits* (Section 5b).	20%	$200 per hospital admission (No deductible)
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*	*All charges*
Family planning		
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	20%	$10 per office visit (No deductible)
Not covered: reversal of voluntary surgical sterilization, genetic counseling, procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term.	*All charges.*	*All charges*

Infertility services	You pay - Standard Option	You pay – High Option
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••*intravaginal insemination (IVI)* ••*intracervical insemination (ICI)*	50%	50% (No deductible)
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* ••*in vitro fertilization* ••*embryo transfer and GIFT* ••*intrauterine insemination (IUI)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Fertility drugs*	*All charges*	*All charges*
Allergy care		
Testing and treatment Allergy injection	20%	$10 per office visit (No deductible)
Allergy serum	Nothing (No deductible)	Nothing (No deductible)
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*	*All charges*

Treatment therapies	You pay – Standard Option	You pay – High Option
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 28. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy. Pre-authorization required • Growth hormone therapy (GHT) Note: – We will only cover GHT when we pre-authorize the treatment. It is covered under your pharmacy benefit. Call MedImpact at 1-800/788-2949 for pre-authorization. They will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	20%	$10 per office visit (No deductible)
Rehabilitative therapies		
Physical therapy, occupational therapy and speech therapy -- • Up to two consecutive months per condition for the services of the following: ••qualified physical therapists; ••speech therapists; and ••occupational therapists. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury.	20%	$10 per office visit (No deductible)
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to $500	20%	Nothing (No deductible)

Rehabilitative therapies – Continue on next page

Rehabilitative therapies *(Continued)*	**You pay - Standard Option**	**You pay – High Option**
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*	*All charges*
Hearing services (testing, treatment, and supplies)		
• Hearing testing for children through age 17 (see *Preventive care, children*)	20%	$10 per office visit (No deductible)
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges*	*All Charges*
Vision services (testing, treatment, and supplies)		
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	20%	Nothing (No deductible)
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care) • Annual eye refractions	20%	$10 per office visit (No deductible)
Not covered: • *Eyeglasses or contact lenses and, after age 17, examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care		
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	20%	$10 per office visit (No deductible)

Foot care – continued on next page

Foot care *(Continued)*	**You pay - Standard Option**	**You pay – High Option**
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charge.*	*All charges*
Orthopedic and prosthetic devices		
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome Note: This benefit combined with the Durable Medical Benefit on page 23 is limited to a maximum payment of $2,500 per calendar year and $50,000 maximum per lifetime. • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.	20%	Nothing (No deductible)
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *cochlear implants* • *prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*	*All charges*

Durable medical equipment (DME)	You pay - Standard Option	You pay – High Option
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. • motorized wheel chairs • This list is not complete, please call Customer Service. Note: This benefit combined with the Orthopedic and prosthetic devices benefit on page 22 is limited to a maximum payment of $2,500 per calendar year and $50,000 maximum per lifetime.	20%	Nothing (No deductible)
Not covered: • *Exercise equipment such as Nordic Track, exercise bicycles.* • *Equipment which is primarily used for non-medical purposes such as hot tubs, massage pillows* • *Convenience items*	*All charges*	*All charges*
Home health services		
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Up to two hours per visit. • Services include oxygen therapy, intravenous therapy and medications. Note: These services require precertification. Please refer to the precertification information shown in Section 3 for precertification guidelines.	20%	Nothing (No deductible)
Not covered: • *nursing care requested by, or for, the convenience of the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* • *Custodial care*	*All charges*	*All charges*

Alternative treatments	You pay - Standard Option	You pay – High Option
No benefit	No benefit	No benefit
Not covered: • *chiropractic services* • *acupuncture* • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges*	*All charges*
Educational classes and programs		
Coverage is limited to: • Smoking Cessation – Up to $150 for one smoking cessation program per member per lifetime. Approved medications obtained at a Plan pharmacy will be covered under the Prescription Drug Benefit to a lifetime maximum of $350 per member.	50% (No deductible)	50% (No deductible)
• Outpatient nutritional guidance counseling – services by a registered dietitian for the following conditions: diabetes, cancer, endocrine conditions, swallowing conditions after stroke, hyperlipidemia. Up to a maximum benefit of $400 per member per year.	20%	$10 per office visit (No deductible)

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- For the Standard Option - The calendar year deductible is $100 per person ($200 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- For High Option there is no deductible for these services
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5 (c). for charges associated with the facility charge (i.e. hospital, surgical center, etc.).
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…	
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.		
Surgical procedures	**You pay - Standard Option**	**You pay – High Option**
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	20%	Nothing (No deductible)
• Surgical treatment of morbid obesity -- a condition in which an individual has a body mass index greater than 40; or a body mass index greater than 35 when the members health is endangered and more conservative medical measures have been unsuccessful, according to current underwriting standards; eligible members must be age 18 or over	50%	50% (No deductible)

Surgical procedures - Continued on next page.

Surgical procedures *(Continued)*	**You pay - Standard Option**	**You pay – High Option**
• Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under your Pharmacy Benefit. • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	20%	$10 per office visit (No deductible)
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges*	*All charges*
Reconstructive surgery		
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy may, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	20%	Nothing (No deductible)

Reconstructive Surgery – Continued on Next Page

Reconstructive surgery	You pay - Standard Option	You pay – High Option
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery		
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	20%	Nothing (No deductible)
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*

Organ/tissue transplants	You pay - Standard Option	You pay – High Option
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Pancreas • Liver • Lung: Single –Double • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or 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. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	20% of charges up to $100,000 50% of charges above $100,000 for heart/lung, single/double lung, liver, and bone marrow transplants.	Nothing 50% of charges above $100,000 for heart/lung, single/double lung, liver, and bone marrow transplants. (No deductible)
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia		
Professional services provided in – • Hospital (inpatient)	20%	Nothing (No deductible)
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	20%	Nothing (No deductible)

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- For the Standard Option - The calendar year deductible is $100 per person ($200 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- For High Option there is no deductible for these services
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by 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 Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay	
NOTE: The calendar year deductible applies to all services on the Standard Option. The High Option does not have a deductible:		
Inpatient hospital	**You pay - Standard Option**	**You pay - High Option**
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	20%	$200 per admission (No deductible)

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay - Standard Option**	**You pay - High Option**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Private nursing care	20%	Nothing (No deductible)
Not covered: • *Custodial care rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Inpatient hospice care* • *Take home medications*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center		
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	20%	Nothing (No deductible)
Not covered: • *blood and blood derivatives not replaced by the member* • *Take home medications*	*All charges*	*All charges*

Extended care benefits/skilled nursing care facility benefits	You pay - Standard Option	You pay – High Option
Extended care benefit: We cover a comprehensive range of benefits with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. Extended care benefits require prior authorization by the Plan's Medical Director.	20%	Nothing (No deductible)
Not covered: custodial care	*All charges*	*All charges*
Hospice care		
Supportive and palliative care for a terminally ill member is covered in the home up to a $5,000 maximum Plan payment per member per calendar year. Services include • medical care • family counseling Note: Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	20%	Nothing (No deductible)
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance		
• Local professional ambulance service when medically appropriate • Air ambulance up to $5,000 per trip. Note: If, you are hospitalized in a non-Plan facility and Plan doctors believe care can be provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.	20%	Nothing (No deductible)

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- For the Standard Option - The calendar year deductible is $100 per person ($200 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- For High Option there is no deductible for these services
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

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

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay	
Emergency within our service area	**You pay - Standard Option**	**You pay - High Option**
• Emergency care at a doctor's office	20%	$10 per office visit (No deductible)
• Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: High Option - If the emergency results in admission to a hospital, inpatient services are subject to the hospital admission copay of $200 (not applicable to accidental injury admissions) and the emergency care copay is waived.	20%	$25 per visit (No deductible)
Not covered: Elective care or non-emergency care	*All charge.*	*All charges*
Emergency outside our service area		
• Emergency care at a doctor's office	20%	$10 per office visit (No deductible)
• Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: High Option - If the emergency results in admission to a hospital, inpatient services are subject to the hospital admission copay of $200 (not applicable to accidental injury admissions) and the emergency care copay is waived.	20%	$25 per visit (No deductible)
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service*	*All charges.*	*All charges*

Ambulance	You pay - Standard Option	You pay - High Option
• Professional ambulance service when medically appropriate. • Air ambulance up to $5,000 per trip Note: If, you are hospitalized in a non-Plan facility and Plan doctors believe care can be provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. See 5(c) for non-emergency service.	20%	Nothing (No deductible)
Not covered:	*All charges*	*All charges*

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

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductible or, for facility care, the inpatient deductible apply to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
Mental health and substance abuse benefits	**You pay - Standard Option** / **You pay - High Option**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions. / Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	20% / $10 per visit (No Deductible)

Mental health and substance abuse benefits – Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay - Standard Option**	**You pay - High Option**
• Diagnostic tests	20%	$10 per visit (No Deductible)
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	20%	$200 per admission (No Deductible)
Not covered: Services we have not approved *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*.	*All charges*	*All charges*

Pre-authorization

To be eligible to receive these benefits you must follow your treatment plan and all of the following authorization processes:

All inpatient stays and outpatient visits must be pre-authorized by the Plan. You or your mental health or substance abuse provider must obtain pre-authorization by calling 1-800-223-6114 before services are provided. If pre-authorization is not obtained, payment for the services will be denied. Note: Pre-authorization is not required for treatment rendered by a state hospital when the member has been involuntarily committed.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care coverage. The transitional period will last for up to 90 days from the date you receive notice of the change. You may receive this notice prior to January 1, 2001, and the 90 day period begins with receipt of the notice.

Network limitation

We may limit your benefits if you do not follow your treatment plan**.**

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Standard Option – this benefit is not subject to a deductible.
- High Option – the calendar year deductible is $600 per member per year.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A Plan or referral physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy.
- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 31-day supply (except certain maintenance drugs approved by the Plan may be dispensed on a 3-month supply basis).
- **When you have to file a claim.** When you use a Plan pharmacy, you will not be responsible for submitting a claim form to the Plan. In the event of an accidental injury or medical emergency, you may utilize the services of a non-Plan pharmacy. For reimbursement, please submit an itemized claim form to: MedImpact, 10680 Treena Street, 5th floor, San Diego, CA 92131.

Prescription drug benefits begin on the next page.

Benefit Description	You pay After the calendar year deductible High Option Only	
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.		
Covered medications and supplies	**You pay - Standard Option**	**You pay – High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Insulin, with a copay/coinsurance charge applied to each vial. • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Prior authorization below) to an annual maximum plan payment of $500 per member • Contraceptive drugs and devices • Growth hormones • Prenatal vitamins during pregnancy	20% (No deductible)	50%
• Smoking cessation medications up to a lifetime maximum of $350 per member	50% (No deductible)	50%
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 360/478-6796	20% (No deductible)	50%

Covered medications and supplies - Continued on next page

Covered medications and supplies *(continued)*	**You pay – Standard Option**	**You pay – High Option**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines (except certain over-the-counter substances approved by the Plan.)* • *Medical supplies such as dressings and antiseptics* • *Drugs for the treatment of infertility* • *Drugs to enhance athletic performance* • *Implanted time-release medications (except those used for contraception, such as Norplant)* • *Drugs prescribed to treat any non-covered service* • *Drugs designated as not covered by the Pharmacy and Therapeutics Committee* • *Compounded drugs for hormone replacement therapy.* • *Drugs that are not medically necessary according to accepted medical, dental or psychiatric practice as determined by the Plan.*	*All charges*	*All charges*

Section 5 (g). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- The calendar year deductible of $25 per member ($50 maximum per family) is required for the services listed under "Basic dental care".
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You pay – Standard Option	You pay – High Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. Sound natural teeth are those that do not have any restoration. The need for these services must result from an accidental injury (not biting or chewing) occurring while the member is covered under the FEHB Program. All services must be performed and completed within 12 months of the date of injury.	20%	Nothing (No Deductible)
Dental benefits		
Preventive dental care – • Diagnostic Full mouth or panorex X-rays – once every 5 years. Bitewing X-rays – once a year Oral exam – once each 6-month period Emergency examination – as determined by the Plan • Preventive Prophylaxis (cleaning) – once each 6-month period Fluoride – once each 6-month period to age 18	20% (No deductible)	No benefit

Dental benefits – continued on next page

Dental benefits *(continued)*	**You pay - Standard Option**	**You pay - High Option**
Basic dental care • Restorative Restoration of carious (decayed) teeth to a state of functional acceptability utilizing filling materials, such as amalgam, silicate or plastic. Application of sealants for permanent molars and bicuspids only (with a 3 year limitation per surface) to age 14. • Oral Surgery Removal of teeth and minor surgical procedures, including surgical and non-surgical extractions, preparation of the alveolar ridge and soft tissues of the mouth for insertion of dentures and general anesthesia when administered in connection with covered oral surgery procedures. • Periodontics Surgical and non-surgical procedures for treatment of the tissues supporting the teeth, including root planning, subgingival curettage, gingivectomy and minor adjustments to occlusion such as smoothing of teeth or reducing cusps. • Endodontics Procedures for pulpal and root canal therapy, including pulp exposure treatment, pulpotomy and apicoectomy • Pedodontics Space maintainers when used to maintain space only. • Diagnosis of or treatment for temporomandibular joint (TMJ) disorders	20%	No benefit
Not covered • *Appliances or restorations necessary to correct vertical dimensions or restore the occlusion* • *Crowns* • *Restoration on the same surface(s) of the same tooth within a two-year period.* • *Ridge extensions for insertion of dentures* • *Major surgical procedures (e.g., mandibular osteotomy)* • *Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting* • *Root planning and/or subgingival curettage more than once in a 12-month period* • *Root canal treatment on the same tooth more than once in a two-year period.* • *Replacement of a space maintainer, previously covered by the Plan* • *Procedures, appliances or restorations primarily for cosmetic purposes or nightguards* • *Orthodontic services* • *Missing teeth* • *Dental services started prior to the date the member enrolled in this Plan* • *Other dental services not shown as covered.*	*All charges*	*All charges*

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan determines it is medically necessary to prevent, diagnose, or treat your illness or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 10.**

We do not cover the following:

- Care by non-Plan providers when received outside the Plan's Service area except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary as determined by the Plan;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices as determined by the Plan;
- Procedures, 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;
- Procedures, services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program or;
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 360-478-6796.

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to: **KPS Health Plans**
Attn: Claims Department
PO Box 339
Bremerton, WA 98337

Prescription drugs

When you must file a claim -- such as for out-of-area care -- submit it on a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name of the pharmacy;
- Dates you received the services or supplies;
- Type of each service or supply;
- The charge for each service or supply; and
- Receipts, if you paid for your services.

Submit your claims to: **MedImpact**
10680 Treena Street, 5th floor
San Diego, CA 92131

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: KPS Health Plans; PO Box 339, Bremerton, Washington 98337 and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II P.O. Box 436, Washington, D.C. 20044-0436. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

The Disputed Claims process *(Continued)*

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 provide a copy of your specific written consent with the review request.

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

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

6 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. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 360/478-6796 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 can call OPM's Health Benefits Contracts Division II at 202/606-3818 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 are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

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

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

- **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.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits wit Medicare, depending on the type of Medicare managed care plan you have.

- **The Original Medicare Plan**

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

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

We will waive some copayments, coinsurance, and deductibles, as follows:

- The copays, deductible and coinsurance applicable to inpatient hospital care and to surgical and medical care; and
- The coinsurance applicable to the Standard Option Prescription Drug Benefit when you use generic or preferred drugs (preferred drug lists are available from Plan pharmacists and Plan doctors.)

Note: The High Option Prescription Drug Benefit deductible of $600 per member per year and 50% coinsurance will still apply.

(Primary payer chart begins on next page.)

The following chart illustrates whether Original 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 either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or	✓	
b) Or, the position is not excluded from FEHB. Ask your employing office which of these applies to you.		✓
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) 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,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member – have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
b) Are an active employee		✓

If Medicare is the primary payer for you and/or your covered dependent, submit your claims or ask your providers to submit your claims to Medicare first. Claims for secondary benefits, together with Medicare's Explanation of Benefits form, should be sent to this Plan after Medicare has paid its benefits.

If Medicare is the secondary payer for you and/or your covered dependent, claims should be submitted to this Plan first, then to Medicare. Be sure the claims include information about your employment or end stage renal disease if appropriate.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. . To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

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

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care service area.

- **Enrollment in Medicare Part B**

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 benefits. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Care you receive in an institution, such as room and board or other supportive care, or in the home that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist you in activities of daily living. Activities of daily living include but is not limited to: help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets, supervision of medications that you would normally self-administer.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or investigational services

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

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

1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, or
2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

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

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

Medical necessity

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

1) It is consistent with the symptom or diagnosis and treatment of the condition.
2) It is the most appropriate supply or level of service that is essential to the members needs.
3) When applied to an inpatient, it cannot be safely provided to the member as an outpatient.
4) It is appropriate with regard to good medical practice.
5) It is not primarily for the convenience of the member or provider.
6) It is the most cost-effective of the alternative levels of service or supplies that are adequate and available.

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

Plan allowance

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

1) Plan providers: The plan allowance is the amount agreed upon between the Plan and the Plan provider. Plan providers agree not to bill you for any charges above our allowance.
2) Non-Plan providers: The Plan allowance is reduced by 25% when you see a non-Plan provider, except in an emergency or with a referral. You are responsible for all charges above the Plan allowance.

Us/We

Us and we refer to KPS Health Plans.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

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 www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you *a Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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 (TCC).

When you lose benefits

- **When FEHB coverage ends**

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

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

  You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **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.

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

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

• Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 360/478-6796 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or are no longer enrolled in the Plan and try to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for the KPS Health Plans - 2001

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the $100 calendar year deductible.
- Note: We only cover services that are provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office ..	High Option: Office visit copay: $10 Standard Option: 20%*	15
Services provided by a hospital:		
• Inpatient	High Option: $200 per admission copay Standard Option: 20%*	29
• Outpatient	High Option: Nothing Standard Option: 20%*	30
Emergency benefits:		
• In-area	High Option: $25 copay Standard Option: 20%*	33
• Out-of-area.....	High Option: $25 copay Standard Option: 20%*	33
Mental health and Substance Abuse treatment.....	High Option: Regular Benefits Standard Option: Regular Benefits	35
Prescription drugs	High Option: $600 deductible then 50% Standard Option: 20% of our allowance	37
Dental Care	High Option: No benefit Standard Option: Preventive Care: 20% of our allowance Basic Dental Care: After deductible of $25 per person or $50 per family 20% of our allowance	40
Vision Care	No benefit	
Protection against catastrophic costs.....	High Option: Inpatient Hospital Copayments; nothing after $600 per family member Standard Option: $2,000/person or $2,000/family per year Some costs do not count toward this protection	12

2001 Rate Information for
Kitsap Physicians Service

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Clallam/Kitsap/Mason/Jefferson/Thurston Counties							
High Option Self Only	**VT1**	**$86.59**	**$78.53**	**$187.61**	**$170.15**	**$102.22**	**$62.90**
High Option Self and Family	**VT2**	**$195.82**	**$157.36**	**$424.28**	**$340.94**	**$231.17**	**$122.01**
Clallam/Kitsap/Mason/Jefferson/Thurston Counties							
Standard Option Self Only	**VT4**	**$86.59**	**$37.52**	**$187.61**	**$81.30**	**$102.22**	**$21.89**
Standard Option Self and Family	**VT5**	**$195.82**	**$75.39**	**$424.28**	**$163.34**	**$231.17**	**$40.04**