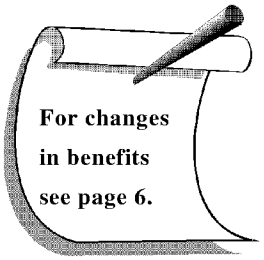
KPS Health Plans 2002

www.kpshealthplans.com

A Prepaid Comprehensive Medical Plan



Serving: Most of Western Washington.

Enrollment in this Plan is limited. You must live or work on our Geographic Service area to enroll. 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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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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means KPS Health Plans.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20416-3650.

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 or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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.

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:

We are 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.

We emphasize 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 First Choice Health Network (FCHN) and MultiPlan Network. **A Plan dentist is any licensed dentist within the State of Washington.**

For the purposes of a dependent child or when you are 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 your, or your dependent's, temporary county of residence, then you or your dependent may see any doctor or dentist practicing within the temporary county of residence at no penalty *(See Service Area)*

We arrange with doctors (620 primary care physicians and 1174 specialists) and hospitals (17), and make referrals to nonparticipating doctors, to provide medical care for both the prevention of disease and the treatment of serious illness.

Your rights

OPM requires that all FEHB Plans to provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. 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 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 www.kpshealthplans.com.

Service Area

To enroll in this Plan, you must live or work in our service area. This is where our providers practice. Our service area covers the counties of Clallam, Grays Harbor, Jefferson, Kitsap, Mason, Pierce 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 the State of Washington, we will pay only benefits for emergency care. We will not pay for any other health care services. Exception: eligible dependent children away at school and when you are on temporary duty assignment outside our service area may receive benefits for other than emergency care when arrangements are made with us.

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 2002

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

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8.)

Changes to this Plan

- Under High Option, your share of the non-Postal premium will increase by 2.5% for Self only or 0.4% for Self and Family.
- Under Standard Option, your share of the non-Postal premium will decrease by 3.5% for Self only or 2.9% for Self and Family.
- We added a new Section after Section 11. to discuss the Long Term Care Insurance Program that is coming in 2002.
- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children. (Section 5(a).)
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a).)
- We clarified the Family planning and Infertility benefits by providing more examples of covered and not covered benefits. (Section 5 (a).)
- We now cover routine screening for chlamydial infection. (Section 5(a).)
- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. Section 5 (a).)
- We clarified Surgical procedures to show that we cover a comprehensive range of services, such as operative procedures. (Section 5(b).)
- We now cover certain intestinal transplants. (Section 5(b).)
- We clarified the brochure to show why we think you should use generic drugs whenever possible. We moved other language around within the Prescription drugs section but didn't change its meaning (Section 5 (f).)
- You may now enroll in this plan if you live or work in our service area as listed on the front cover.
- Under Standard Option, you may choose any licensed dentist within the State of Washington for your dental care.
- Under Standard Option, your annual deductible will increase from $100 to $200 for an individual and from $200 to $400 for a family.
- Under Standard Option, your annual out-of-pocket maximum for family enrollment will increase from $2,000 to $4,000.
- You no longer are required to satisfy the annual deductible in order to receive benefits for preventive care services for adults.
- You now have benefits for up to 12 (twelve) chiropractic visits per calendar year under the Standard and High Option plans.
- You now have benefits for up to 12 (twelve) acupuncture treatments per calendar year when treatment is received from a licensed Plan provider.
- You will pay 50% of all charges above $100,000 for kidney/pancreas transplants.
- Under Standard Option you will pay $5 per prescription or refill for Tier 1 (generic) drugs, $15 per prescription or refill for Tier 2 (preferred) drugs, and $100 or 50% whichever costs you less per prescription or refill for Tier 3 (non-preferred) drugs.
- Under Standard Option, your dental plan benefits will now be limited to $1,000 per member per calendar year.
- When you have Original Medicare and Standard Option you will now be responsible for the applicable copayments of $5 per prescription or refill for Tier 1 (generic) drugs, $15 per prescription or refill for Tier 2 (preferred) drugs, and $100 or 50% whichever costs you less per prescription or refill for Tier 3 (non-preferred) drugs.
- We clarified the Medicare Primary Payer Chart to explain how we coordinate benefits for former spouses. (Section 9.)
- We clarified other language about coordinating benefits with Medicare. (Section 9.)

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.

Our 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 Member Services Department at 360/478-6796 or toll free (in Washington State) 800/552-7114. You can also find out if your doctor participates with us 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 us 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 www.kpshealthplans.com.

What you must do to get covered care

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 our medical director's opinion, 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 us 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
  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - Reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 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
- 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
- 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 us 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. We 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.

We will send you written confirmation of the approved admission, once certification is obtained. If an emergency admission occurs, have your attending physician and the hospital contact us 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 or facility when you receive services.

Example: Under High Option, 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 $200 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 $400 under Standard Option. This deductible is waived for preventive care and accidental injuries on the Standard Option.

- We also have a separate deductible for Prescription Drugs under 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 at another time during the year, you must begin a new deductible 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 the 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. Under Standard Option you pay 20% coinsurance for most services.

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

Your catastrophic protection 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 $4,000 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
- 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 6 for how our benefits changed this year and page 53 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) 800/552-7114 or at our website at www.kpshealthplans.com.

(a) Medical services and supplies provided by physicians and other health care professionals 13-22

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Physical and occupational therapies
- Speech therapy
- Hearing services (diagnosis and treatment of diseases of the ear)
- Vision services (diagnosis and treatment of diseases of the eye)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Chiropractic
- Alternative treatments
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals 23-26

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility and ambulance services 27-29

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents 30-31

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits 32-33

(f) Prescription drug benefits 34-35

(g) Dental benefits 36-37

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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.
- Under Standard Option - The calendar year deductible is $200 per person ($400 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.
- Under 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 exam of a newborn child covered under a family enrollment	20%	Nothing
At home	20%	$15 per visit (No deductible)
Not covered: • *Non-surgical treatment of morbid obesity* • *Treatment of impotence (unless we determine it 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
Preventive care, adult		
Routine screenings, such as: • Complete Blood Count – One annually • Total Blood Cholesterol – once every three years • Colorectal cancer screening, including – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50	20% (No deductible)	Nothing
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	20% (No deductible)	Nothing
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	20% (No deductible)	Nothing
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% (No deductible)	Nothing

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	Nothing
Preventive care, children		
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Well-child care charges for routine examinations, immunizations and care (through age 22)	Nothing	Nothing
• 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	20% (No deductible)	$10 per office visit (No deductible)
Maternity care		
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 10 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 5(c).) and *Surgery benefits* (Section 5(b).)	20%	$200 per hospital admission (No deductible)
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*	*All charges*

Family planning	You pay – Standard Option	You pay – High Option
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms NOTE: We cover oral contraceptives under the prescription drug benefit.	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 or when the pregnancy is the result of an act of rape or incest*	*All charges*	*All charges*
Infertility services		
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, gamete GIFT and zygote ZIFT* – *Zygote transfer* – *Intrauterine insemination (IUI)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*	*All charges*

Allergy care	You pay - Standard Option	You pay – High Option
Testing and treatment Allergy injection	20%	$10 per office visit (No deductible)
Allergy serum	Nothing	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*	*All charges*
Treatment therapies		
• 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 26. • 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: Growth hormone is covered under the prescription drug benefit. Note: We will only cover GHT when we pre-authorize the treatment. It is covered under your pharmacy benefit. Call MedImpact at 800/788-2949 for pre-authorization. They will ask you to submit information that establishes that 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 GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	20%	$10 per office visit (No deductible)
Physical and occupational therapies		
• Up to two consecutive months per condition for the services of the following: – Qualified physical therapists and – Occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	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
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*

Speech therapy	You pay – Standard Option	You pay – High Option
• Up to $1,000 of treatment per condition for the services of the following: – □ Licensed speech therapist	20%	$10 per office visit (No deductible)
Hearing services (testing, treatment, and supplies)		
• Hearing testing for children through age 17 (see *Preventive care, children*)	20% (No deductible)	$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) • Annual eye refractions	20%	Nothing
• Eye exam to determine the need for vision correction for children through age 17 (see Preventive care)	20% (No deductible)	$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)
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 charges*	*All charges*

Orthopedic and prosthetic devices	You pay - Standard Option	You pay – High Option
• 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 20 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: We pay internal prosthetic devices as hospital benefits: see Section 5(c). for payment information. See section 5(b). for coverage of the surgery to insert the device.	20%	Nothing
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 • Insulin pumps • Motorized wheel chairs Note: This list is not complete, please call Member Services. Note: This benefit combined with *the Orthopedic and prosthetic devices* benefit on page 19 is limited to a maximum payment of $2,500 per calendar year and $50,000 maximum per lifetime.	20%	Nothing
Not covered: • *Exercise equipment such as Nordic Track and/or exercise bicycles* • *Equipment which is primarily used for non-medical purposes such as hot tubs and 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 pre-certification guidelines.	20%	Nothing
Not covered: • *Nursing care requested by, or for, the convenience of the patient or the patient's family* • *Services primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*

Chiropractic	You pay - Standard Option	You pay – High Option
• Up to 12 treatments per calendar year for manipulation of the spine and extremities	20%	$10 per office visit (No deductible)
Not covered: • *Manipulation of the extremities* • *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy and cold pack application.*	*All charges*	*All charges*
Alternative treatments		
• Acupuncture - up to 12 treatments per calendar year when treatment is received by a licensed Plan provider	20%	$10 per office visit (No deductible)
Not covered: • *Herbs prescribed by an acupuncturist or naturopath* • *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.	20% (No deductible)	$10 per office visit (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)

Sleep Disorders	You pay - Standard Option	You pay – High Option
• **Sleep studies –** (including polysomnograph, multiple sleep latency tests, continuous positive airway pressure (CPAP) studies, and durable medical equipment and supplies) will be covered for the following sleep disorders when diagnosed and referred by a Plan physician: narcolepsy, and sleep apnea syndrome (such as obstructive upper airway and/or central sleep apnea). Other conditions may be payable upon review by the Medical Director. Sleep studies are limited to a lifetime maximum of $5,000. • **Surgical treatment –** of the above listed sleep disorders will be limited to a lifetime maximum of $3,000.	50%	50% (no deductible)
Not covered: Any service not listed above for the purpose of studying, monitoring and/or treating sleep disorders.	*All charges*	*All charges*

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.
- Under Standard Option the calendar year deductible is $200 per person ($400 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.
- Under 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.).
- YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR 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**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See Section 5(a). *Orthopedic and prosthetic devices* for device coverage information.	20%	Nothing
• Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards: eligible members must be age 18 or over	50%	50% (No deductible)

Surgical procedures - Continued on next page.

Surgical procedures *(Continued)*	**You pay - Standard Option**	**You pay – High Option**
• Voluntary sterilization • 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, Section 5(a).*	*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
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	You pay - Standard Option	You pay – High Option
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
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		
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 • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. Limited to those transplants that meet our protocols. 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 our medical director in accordance with the our protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	20% of charges for cornea, heart, kidney, and pancreas transplants up to $100,000, nothing thereafter. For heart/lung, single/double lung, liver, kidney/pancreas, intestinal transplants and bone marrow transplants only, 20% of charges up to $100,000 and 50% of charges thereafter.	Nothing for cornea, heart, kidney, and pancreas transplants. For heart/lung, single/double lung, liver, kidney/pancreas, intestinal transplants and bone marrow transplants only, nothing of charges up to $100,000 and 50% of charges thereafter. (No deductible)

Organ/tissue transplant continued on next page.

Organ/tissue transplants	You Pay – Standard Option	You Pay – High Option
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) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	20%	Nothing

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.
- Under Standard Option the calendar year deductible is $200 per person ($400 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.
- Under 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).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR 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
Not covered: • *Custodial care rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing homes, 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
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 us. Extended care benefits require prior authorization by the our Medical Director.	20%	Nothing
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
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

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.
- Under Standard Option the calendar year deductible is $200 per person ($400 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.
- Under 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 enrolled with us so they can notify us. You or a family member should notify us within 48 hours. It is your responsibility to ensure that we have been notified in a timely manner.

If you need to be hospitalized, we **must** be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in 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 us, 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, we must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If 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 us, any follow-up care recommended by non-Plan providers must be approved by us 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: Under 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 charges*	*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: Under 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

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

IMPORTANT

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 FOR 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 obtain a treatment plan and follow 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 800/223-6114 before services are provided. If pre-authorization is not obtained, payment for the services will be reduced. Note: Pre-authorization is not required for treatment rendered by a state hospital when the member has been involuntarily committed.

Limitation

We may limit your benefits if you do not obtain a 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.
- Under Standard Option – this benefit is not subject to the calendar year deductible.
- Under 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). Maintenance drugs will be subject to 2 copayment for a 3-month supply.

  A generic equivalent will be dispensed if it is available, unless you physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

- **We do not have a formulary.** We do not base our prescription drug benefit on a formulary. Rather, we classify all drugs into one of three "tier" categories:

  – Tier 1 Drugs, generally generic, have the lowest associated copayment.

  – Tier 2 Drugs, also called 'preferred drugs', have a slightly higher copayment.

  – Tier 3 drugs, also known as 'non-preferred' drugs, are all other drugs which are not on our drug list. Tier 3 drugs have the highest copayment.

  Because of their lower cost to you, we recommend that you ask your provider to prescribe Tier 1 or Tier 2 ('preferred') drugs rather than Tier 3 ('non-preferred') drugs. To order a prescription drug brochure, call us at 360/78-6796 or toll free at 800/552-7114. You may also access the prescription drug list on our website at: www.kpshealthplans.com.

  Preferred drug means a branded, single source agent or generic drug that has been determined as preferred by us.

  Non-preferred drug means a branded, single source agent or generic drug that has been determined as non-preferred by us.

- **Why use Generic Drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.
- **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. • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • 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 • Smoking cessation medications up to a lifetime maximum of $350 per member	Tier 1 (Generic) drugs – $5 per prescription/refill Tier 2 (Preferred) drugs – $15 per prescription/refill Tier 3 (Non-Preferred) drugs – $100 or 50% whichever costs the member less per prescription/refill (No deductible)	50% 50%
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* • *Fertility drugs* • *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 obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *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".
- The calendar year maximum for all services combined is $1,000 per member.
- 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
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 planing, 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 planing 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 we determine it is medically necessary to prevent, diagnose, or treat your illness or condition. Certain services require pre-authorization and may be excluded unless the procedure discussed under *What Services Require Our Prior Approval* on page 9 is followed.**

We do not cover the following:

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

Submit your claims to: **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 1900 E Street, NW, Washington, D.C. 20415-3620. 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 include a copy of your specific written consent with the review request.

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

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

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 or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 800/MEDICARE (800/633-4227) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly social Security check or your retirement check.

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 with Medicare, depending on the type of Medicare managed care plan you have.

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

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

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

We will waive copayments, coinsurance, and deductibles applicable to inpatient hospital care and to surgical and medical care; and covered dental benefits.

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

(Primary payer chart begins on next page.)

The following chart illustrates whether **the Original Medicare Plan** 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, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of 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.

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 360/478-6796 or toll-free at 800/552-7114.

We waive some costs when you have the Original Medicare Plan: When Original Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

- Copayments, coinsurance, and deductibles applicable to inpatient hospital care, surgical and medical care and covered dental benefits.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan -- 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 provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 800/MEDICARE (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. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

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 11.

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; and
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. We determine our allowance as follows:

1) Plan providers: Our allowance is the amount agreed upon between us and the Plan provider. Plan providers agree not to bill you for any charges above our allowance.
2) Non-Plan providers: Our 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 our 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
- 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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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
- 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 of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **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.

- **Temporary continuation of coverage (TCC)**

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

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

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

- **Converting to individual coverage**

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many people now consider long term care insurance to be vital to their financial and retirement planning.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

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

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Summary of benefits for the KPS Health Plans - 2002

- **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 $200 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%*	13
Services provided by a hospital: • Inpatient	High Option: $200 per admission copay Standard Option: 20%*	27
• Outpatient	High Option: Nothing Standard Option: 20%*	28
Emergency benefits: • In-area	High Option: $25 copay Standard Option: 20%*	31
• Out-of-area	High Option: $25 copay Standard Option: 20%*	31
Mental health and Substance Abuse treatment	High Option: Regular Benefits Standard Option: Regular Benefits	32
Prescription drugs	High Option: $600 deductible then 50% Standard Option: Tier 1 - $5 /Tier 2 - $15 /Tier 3 - 50% to a maximum of $100	34
Dental Care	High Option: No benefit Standard Option: Preventive Care: 20% of our allowance Class II (Basic) Dental Care: After deductible of $25 per person or $50 per family 20% of our allowance $1,000 annual maximum per member.	36
Vision Care	Annual eye refractions High Option: Office visit copay $10 Standard Option: 20% * Eye exam for children through age 17 High Option: office visit copay: $10 Standard Option: 20%*	18
Protection against catastrophic costs	High Option: Inpatient Hospital Copayments; nothing after $600 per family member Standard Option: $2,000/person or $4,000/family per year Some costs do not count toward this protection	11

2002 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 (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 who are not career postal employees. 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/Grays Harbor/Kitsap/Mason/Jefferson/Pierce/Thurston Counties							
High Option Self Only	VT1	$97.86	$80.47	$212.03	$174.35	$115.52	$62.81
High Option Self and Family	VT2	$223.41	$158.03	$484.06	$342.39	$263.75	$117.69
Clallam/Grays Harbor/Kitsap/Mason/Jefferson/Pierce/Thurston Counties							
Standard Option Self Only	VT4	$97.86	$36.19	$212.03	$78.41	$115.52	$18.53
Standard Option Self and Family	VT5	$219.68	$73.23	$475.98	$158.66	$259.96	$32.95