KPS Health Plans

Kitsap Physicians Service 1999

A Prepaid Comprehensive Medical Plan

Serving: Kitsap, Mason and Jefferson Counties in Northwestern Washington
Enrollment in this Plan is limited; see pages 7-8 for requirements.

Enrollment code:

High Option

VT1 Self Only
VT2 Self and Family

Standard Option

VT4 Self Only
VT5 Self and Family

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at http://www.kpshealthplans.com

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73-051

Kitsap Physicians Service

Kitsap Physicians Service, 400 Warren Avenue, P.O. Box 339, Bremerton, Washington, 98337, has entered into a contract (CS 1767) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Kitsap Physicians Service, KPS, or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on page 21 of this brochure.

Table of Contents

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation—sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Plan at 360/478-6796 and explain the situation.
- If the matter is not resolved after speaking to your Plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, DC 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claims files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education. As part of its administration of the prescription drug benefits, the Plan may disclose information about a member's prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor, except in the case of emergency, as described on pages 14-16.** If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See *If you are hospitalized* below.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last

day of your

General Information *continued*

If you are hospitalized (cont.)

enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The **benefits** in this brochure are effective on January 1 for those already enrolled on this Plan; if you changed plans or plan options, see *"If you are a new member"* above. In both cases, however, the Plan's new **rates** are effective the first day of January for all enrollees and annuitants.
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

  Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

  You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Things to keep in mind (cont.)

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements

Separating employees — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

General Information *continued*

Notification and election requirements (cont.)

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available—or chosen—when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of creditable coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Facts about this Plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays them directly for their services. Full benefits are available **only** from Plan providers except during a medical emergency. **Members are encouraged to select a personal doctor from among participating Plan primary care doctors and to receive referrals for specialty care from their primary care doctor. There are no claim forms when Plan doctors are used.**

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan places great emphasis on preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Information you have a right to know

All plans in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Plan at 360 / 478-6796 or you may write the Plan at P.O. Box 339, Bremerton, Washington 98337. You may also contact the Plan by fax at 360 / 415-6514, or at its website at http://www.kpshealthplans.com.

Information that must be made available to you includes:

- Disenrollment rates for 1997
- Compliance with State and Federal licensing or certification requirements and the dates met.
- Accreditations by recognized accrediting agencies and the dates received.
- Plan's type of corporate form and years in existence.
- Whether the Plan meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Facts about this Plan *continued*

Who provides care to Plan members?

The Plan emphasizes comprehensive medical and surgical care in Plan doctors' offices and hospitals. A Plan doctor is a participating provider with KPS. A Plan dentist is a participating dentist with KPS.

For the purposes of a dependent child residing outside the state of Washington, a Plan doctor or Plan dentist shall also include doctors or dentists practicing within the dependent's temporary county of residence.

The Plan arranges with doctors (579 primary care doctors and 617 specialists) and hospitals (3), and makes referrals to nonparticipating doctors, to provide medical care for both the prevention of disease and the treatment of serious illness.

Role of a primary care doctor

You are urged to choose a family doctor to assume primary responsibility for your care, select a pediatrician for your children, have periodic checkups, seek medical advice and get prompt attention at the first sign of illness. If, in the opinion of the Plan's medical director, your utilization of covered benefits appears to be excessive for proper medical care, you may be required to designate a doctor of your choice from the Plan's participating doctors who will arrange for coordination of your medical care and for referrals to other doctors with the exception that a woman may see her Plan gynecologist for her annual routine examination without referral. It is the responsibility of your doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization.

Choosing your doctor

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, internists) with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Service Department at 360 / 478-6796 or toll free (in Washington State) 1-800 / 552-7114. You can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a **specific** provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. **Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/ or participation of any one doctor, hospital, or other provider cannot be guaranteed.**

In the event a member is receiving services from a doctor who terminates a participation agreement, the Plan will provide payment for covered services until the Plan can make reasonable and medically appropriate provisions for the assumption of such services by a participating Plan doctor.

Case Management

The plan, in its sole discretion, may elect to provide alternative benefits which are not listed as covered services in this brochure. The alternative covered benefits shall be determined on a case-by-case basis by the Plan for services which it deems are medically necessary, cost effective, and agreeable to the member and Plan doctor. The Plan shall not be committed to provide these same or similar alternative benefits for another member, nor shall the Plan lose the right to strictly apply the express provisions of this brochure for future services or benefits.

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor must obtain the Plan's determination of medical necessity.

Hospital care

If you require hospitalization, your Plan doctor or authorized specialist will make the necessary arrangements and continue to supervise your care. Under the Mental Conditions inpatient benefit, if a member's hospitalization extends from one contract year to the next and reaches or exceeds the covered benefit of 30 days, the member must be discharged before the new year's benefit of 30 days becomes available.

Deductible

High Option only—There is a separate deductible for prescription drugs under the High Option of $600 per member per calendar year.

Standard Option only—The deductible is the amount of covered expenses a member must incur each calendar year before the Plan starts paying benefits. The deductible is $100 per person and is not reimbursable by the Plan. After $200 in deductibles has been satisfied by family members covered under the same enrollment, no further deductibles are required that calendar year. You can count toward the deductible only expenses for those services that are listed as covered in this brochure. The deductible is waived for covered medical expenses incurred as a result of accidental injuries.

Out-of-pocket maximum

High Option—Copayments are required for a few benefits. However, the Plan has established a maximum amount of $600 per member per calendar year that you must pay for hospital copayments.

Out-of-pocket maximum (cont.)

Standard Option—In addition to the deductible described above, coinsurance is required for most benefits. Coinsurance is a cost sharing requirement whereby the member assumes a percentage (20%) of the costs for covered services. However, the Plan has established a maximum amount of $2,000 per person ($2,000 per family), per calendar year of total coinsurance charges required for services provided or arranged by the Plan. This coinsurance maximum does not include: (a) costs of prescription drugs or dental services; or (b) services for which the member's coinsurance percentage level is greater than 20 percent (i.e., services of non-Plan providers, allergy serum, transplant costs in excess of $100,000, diagnosis and treatment of infertility, smoking cessations costs, and costs for outpatient treatment of mental conditions/substance abuse).

You should maintain accurate records of the copayments/coinsurance made, as it is your responsibility to determine when the maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments/coinsurance are due when service is rendered, except for emergency care.

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Experimental or investigational definition

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 (for use other than its intended purposes and labeled intentions), 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 post marketing approval clinical trials, and devices classified by the FDA as "Category B Non-experimental/Investigational Devices" are not considered experimental or investigational.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's service area

The service area for this Plan, where Plan providers and facilities are located, is described below. You must live inside the service area to enroll in this Plan. Benefits for care received from non-Plan doctors outside the service area are limited to emergency services, as described on pages 14-16.

Eligible dependent children away at school outside the Plan's Service Area may receive benefits for other than emergency care when arrangements are made with the Plan.

Facts about this Plan *continued*

The Plan's service area (cont.)

If you or a covered family member move outside the enrollment area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

Service area: The counties of Jefferson, Kitsap and Mason.

Kitsap Physicians Service and Medicare

If you are enrolled in Medicare Part B, and Medicare is the primary payer, this Plan will waive: (a) the copays, deductible and coinsurance applicable to inpatient hospital care and to surgical and medical care; and (b) the coinsurance applicable to the Standard Option prescription drug benefit when you use generic or preferred drugs (preferred drug lists are available from Plan pharmacists and Plan doctors). However, the High Option Prescription Drug Benefit deductible of $600 per member per year and 50% coinsurance will still apply.

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.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is the official statement of benefits on which you can rely.

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, unless you use Plan providers. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first)

General Limitations *continued*

Group health insurance and automobile insurance (cont.)	is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.
CHAMPUS	If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.
Medicaid	If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.
Worker's compensation	The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).
DVA facilities, DoD facilities and Indian Health Service	Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.
Other government agencies	The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.
Liability insurance and third party actions	If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless the Plan determines it is medically necessary to prevent, diagnose or treat your illness or condition as discussed under Authorizations on page 6. The following are excluded:**

- Care by non-Plan doctors or hospitals when received outside the Service Area except for Plan-authorized referrals or emergencies (see *Emergency Benefits*)
- Expenses incurred while not covered by this Plan
- Services furnished or billed by a provider or facility barred from the FEHB Program
- Services not required according to accepted standards of medical, dental or psychiatric practice, as determined by the Plan
- Procedures, treatments, drugs or devices that are experimental or investigational, as determined by the Plan
- Procedures, services, drugs and supplies related to sex transformations; and
- 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.

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

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. Tests 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 outpatient 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

Pre-admission certification provides advanced confirmation of benefits from the Plan before you are admitted to a hospital or skilled nursing facility.

You and your Plan doctor must request pre-admission certification before hospitalization. This is a feature which 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.**

Pre-admission certification authorizes inpatient hospital benefits and is valid for six months. Approval for each admission or readmission is required. The Plan will provide coverage only for the number of hospital days which have been pre-certified. If you hospital stay is extended due to complications, your Plan doctor must obtain benefit authorization for the extension.

After your physician notifies you that hospitalization or skilled nursing care is necessary, ask your physician to obtain pre-admission certification. Written confirmation of the approved admission will be sent to you by the Plan once certification is obtained. If an emergency admission occurs, have your attending physician and the hospital contact the Plan within 48 hours of admission, or as soon as reasonably possible, to complete the certification process.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits and, within the Service Area, house calls if in the judgment of the Plan doctor such care is necessary and appropriate.

High Option—You pay a $10 office visit copay, but no additional copay for laboratory tests and x-rays; $15 copay for a doctor's house call; nothing for visits by nurses and health aides.

Standard Option—You pay 20% of charges after a $100 per member deductible.

The following services are included:

- Preventive care, including well-baby care and periodic checkups (copays, deductibles, and coinsurance are waived for well-baby care up to age 3)
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters (copays, deductibles, and coinsurance are waived for immunizations through age 22)
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment (copays and deductibles for the newborn child will be waived in this instance—coinsurance will still be applied); other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment; allergy test materials; **you pay** 50% of charges for allergy serum
- The insertion of internal prosthetic devices (including the cost of the device) such as pacemakers and artificial joints
- Cornea, heart, heart/lung, single/double lung, kidney and liver transplants; 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, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Transplants are covered when approved by the Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan. **You pay** 50% of costs above the first $100,000 for all services associated with any listed transplant including any re-transplant within one year of the initial transplant.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Orthopedic devices, such as braces; prosthetic devices, such as artificial limbs and external lenses following cataract removal; and durable medical equipment, such as wheelchairs and hospital beds, including colostomy supplies

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

What is covered (cont.)

- Oxygen and the rental of related equipment
- Home health services of nurses, health aides, and medical social workers, for up to two hours per visit, including intravenous fluids and medications when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers. The Standard Option deductible and coinsurance apply.

Non-Plan providers

For both options, if you use the services of non-Plan providers in the KPS Service Area, payment will be made to you of up to 75% of the KPS Maximum Schedule of Allowances, and you will be responsible for the difference between the provider's charges and the Plan's allowance. All applicable copays, deductibles and coinsurance will be applied. No coverage is provided for services of non-Plan providers outside the KPS Service Area except for emergencies or Plan-authorized referrals. Elective surgery performed by a non-Plan provider must be authorized in advance by the Plan's Medical Director.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for nondental medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two consecutive months per condition if significant improvement can be expected within two months; **you pay** appropriate copays or deductible and coinsurance as stated on pages 6-7, as for office visits. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self care and improved functioning in other activities of daily living. Room and board charges will be covered only if skilled nursing care is medically necessary and prior approval is obtained from the Plan's Medical Director.

Diagnosis and treatment of infertility is covered; **you pay** 50% of covered charges. The following types of **artificial insemination** are covered; intravaginal insemination (IVI) and intracervical insemination (ICI); **you pay** 50% of covered charges; cost of donor sperm is not covered. Fertility drugs are not covered. Other **assisted reproductive technology (ART) procedures**, such as in vitro fertilization, intrauterine insemination (IUI), and embryo transfer, are not covered; drugs for the treatment of infertility are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to a maximum Plan payment of $500; **you pay** all costs after the first $500.

Smoking cessation: The following services will be provided at 50% of charges when directly related to selected smoking cessation programs: The services of a Plan doctor, hospital, psychologist or licensed smoking cessation provider will be covered to a lifetime maximum of $150 per member. Approved medications obtained at a Plan pharmacy will be covered under the Prescription Drug Benefit to a lifetime maximum of $350 per member. This benefit is not subject to the deductible. No other benefits for smoking cessation are available.

Morbid obesity: Surgical treatment of morbid obesity, including gastric bypass surgery or gastric stapling (prior Plan approval is required); **you pay** 50% of covered charges.

Outpatient nutritional guidance counseling by a registered dietician if the services are recommended by a Plan doctor for the following conditions: diabetes, cancer, endocrine conditions, swallowing conditions after stroke, hyperlipidemia. Other conditions may be payable upon review by the Medical Director. Coverage is NOT provided for weight control, obesity, or surgical procedures for weight reduction. The maximum benefit payable is $400 per member per year.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Medical and Surgical Benefits *continued*

Limited benefits (cont.)

Sleep disorders: $8,000 lifetime maximum (Must be approved by the Plan)

(a) 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 doctor: 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 per member. **You pay** 50% of covered charges.

(b) Surgical treatment of the above-listed sleep disorders will be limited to a lifetime maximum of $3,000 per member. **You pay** 50% of covered charges.

No other benefits will be provided for the purpose of studying, monitoring and/or treating sleep disorders.

What is not covered

- Physical examinations and immunizations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel, or because a person works in an environment with a high risk of exposure
- All treatment for obesity, except for the surgical treatment of morbid obesity that may include gastric bypass surgery or gastric stapling
- Treatment for impotence (unless determined by the Plan to be medically necessary)
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Hearing aids
- Transplants not listed as covered
- Foot orthotics
- Chiropractic services
- Homemaker services
- Self-help training (programs or treatments which are designed to aid or improve one's self)
- Acupuncture; naturopathy; biofeedback; massage therapy
- Long-term outpatient rehabilitative therapy
- Palliative or cosmetic foot care; treatment of subluxations of the foot, flat foot conditions, fallen arches, chronic foot strain, weak feet; care of corns, calluses, toe nails, and bunions (except capsular or bone surgery)

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor

High Option—You pay a $200 copay per inpatient admission.

Standard Option—You pay 20% of charges after a $100 deductible.

All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care.
- Specialized care units, such as intensive care or cardiac care units.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Hospital/Extended Care Benefits *continued*

What is covered (cont.)

Extended care

The Plan provides a comprehensive range of benefits with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. Extended care benefits require prior authorization by the Plan's Medical Director

High Option—You pay nothing.

Standard Option—You pay 20% of charges after a $100 deductible.

All necessary services are covered, including:
- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home. Services include medical care and family counseling; these 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. There is a $5,000 maximum Plan payment per member per calendar year.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for non-medical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care
- Inpatient hospice care

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Emergency Benefits

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 the Plan may determine are medical emergencies—what they all have in common is the need for quick action.

Emergencies within the service area

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

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

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

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

Emergency Benefits *continued*

Plan pays . . .

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay . . .

High Option—You pay a $25 copay per visit for emergency care services at an emergency room or urgent care center which are covered benefits of this Plan. 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.

Standard Option—You pay 20% of charges after $100 deductible for emergency care services at an emergency room or urgent care center which are covered benefits of this Plan.

Emergencies outside the service area

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

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

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

Plan pays . . .

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay . . .

High Option—You pay a $25 copay per visit for emergency care services at an emergency room or urgent care center which are covered benefits of this Plan. 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.

Standard Option—You pay 20% of charges after a $100 deductible for emergency care services at an emergency room or urgent care center which are covered benefits of this Plan.

What is covered

- Emergency care at a doctor's office or at an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is not covered

- Elective care or nonemergency 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 area

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 19-20.

Mental Conditions/Substance Abuse Benefits

Mental conditions

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Mental Conditions/Substance Abuse Benefits *continued*

Mental conditions (cont.)

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing—each hour of psychological testing counts as, and is paid as, one office visit (maximum two per year)
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Under both options, **you pay** 50% of charges.

Inpatient care

Up to 30 days of hospitalization each calendar year. If a hospitalization extends from one contract year to the next and reaches or exceeds the covered benefit of 30 days, the member must be discharged before the new year's benefit of 30 days becomes available.

High Option—You pay nothing during the first 30 days—all charges thereafter.

Standard Option—You pay 20% of charges after a $100 deductible during the first 30 days—all charges thereafter.

What is not covered

- Care for psychiatric conditions that in the professional judgment of the Plan are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by the Plan to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition
- Biofeedback, self-help, stress management
- Family or marital counseling
- Diagnosis or treatment of developmental delay, speech delay, or learning disabilities

Substance abuse

All inpatient stays and outpatient visits must be pre-authorized by the Plan. You or your substance abuse provider must obtain pre-authorization by calling 1-800-223-6114 before services are provided. If pre-authorization is not obtained, payment for the services will be denied.

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and, to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

Under both options **you pay** 50% of charges.

Inpatient care

For both options, the Plan pays up to $5,000 for substance abuse rehabilitation (intermediate care) programs per 24-month period in a Plan-designated hospital or State-approved center; **you pay** all charges in excess of $5,000.

What is not covered

- Treatment that is not authorized by the Plan.
- Court-ordered treatment for substance abuse, unless determined by the Plan to be necessary and appropriate.

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy 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).

High Option—You pay a $600 deductible per member per year and 50% of charges thereafter.

Standard Option—You pay 20% of charges.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Insulin, with a copay / coinsurance charge applied to each vial
- Diabetic supplies, including insulin syringes, needles, glucometers, glucose test tablets and test tape, Benedict's solution, or equivalent, and acetone test tablets
- Prenatal vitamins during pregnancy
- Disposable needles and syringes needed to inject covered prescribed medication
- Growth hormones
- Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs, are covered under Medical and Surgical Benefits
- Drugs for the treatment of impotence (when determined by the Plan to be medically necessary) to an annual maximum Plan payment of $500 per member.
- Smoking cessation: under both options, approved medications obtained at a Plan pharmacy will be provided at 50% of charges when directly related to selected smoking cessation programs to a lifetime maximum of $350 per member.

What is not covered

- Drugs available without a prescription or for which there is non-prescription equivalent available (except certain over-the-counter substances approved by the Plan)
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription, except as specified above
- Medical supplies such as dressings and antiseptics
- Oral and injectable contraceptive drugs; contraceptive diaphragms; intrauterine devices (IUDs)
- Drugs for the treatment of infertility
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Implanted time-release medications, such as Norplant
- Drugs prescribed to treat any non-covered service
- Drugs designated by the Plan Pharmacy and Therapeutics Committee (which is made up of Plan doctors and Plan pharmacists) unless authorized by a Plan doctor.

Other Benefits

Dental care

What is covered (Standard Option only)

Preventive dental care

The following preventive and diagnostic dental services are covered when provided by Plan dentists. No deductible is required.

Diagnostic	You Pay
Bitewing X-rays—once a year	20% of charges
Oral exam—once each 6-month period	20% of charges
Preventive	
Prophylaxis (cleaning)—once each 6-month period	20% of charges
Fluoride—once each 6-month period to age 18	20% of charges

No coverage is provided for diagnostic or preventive care rendered by non-Plan dentists within or outside the KPS service area. You will be reimbursed up to 80% of KPS maximum Schedule of Allowances for emergency services required when you are over 100 miles from home and a Plan dentist is not available.

Basic dental care

The following basic dental services are covered when provided by participating Plan dentists: A deductible of $25 per member ($50 maximum per family) per year is required for these services.

Restorative	
Restoration of carious (decayed) teeth to a state of functional acceptability utilizing filling materials, such as amalgam, silicate or plastic.	20% or charges
Application of sealants of permanent molars and bicuspids only (with a 3-year limitation per surface) to age 14.	20% of charges
Oral Surgery	
Removal of teeth and minor surgical procedures, including surgical and nonsurgical 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.	20% of charges
Periodontics	
Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth, including root planning, subgingival curettage, gingivectomy and minor adjustments to occlusion such as smoothing of teeth or reducing cusps.	20% of charges
Endodontics	
Procedures for pulpal and root canal therapy, including pulp exposure treatment, pulpotomy and apicoectomy.	20% of charges
Pedodontics	
Space maintainers when used to maintain space only.	20% of charges

What is not covered

- Appliances or restorations necessary to correct vertical dimensions or restore the occlusion are not covered
- Restorations on the same surface(s) of the same tooth are covered once in a two-year period
- Ridge extensions for insertion of dentures are not covered
- General anesthesia is covered only when administered by a dentist in connection with a covered oral surgery procedure
- Major surgical procedures (e.g. mandibular osteotomy) are not covered
- Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting is not covered
- Root planing and/or subgingival curettage is covered once in a 12-month period
- Root canal treatment on the same tooth is covered only once in a two-year period
- Replacement of a space maintainer, previously covered by the Plan is not covered
- Procedures, appliances or restorations primarily for cosmetic purposes or night guards, including all charges for Orthodontic Services
- Coverage for teeth missing, or dental services started prior to the date the member enrolled in this Plan
- Diagnosis of or treatment for temporomandibular joint (TMJ) disorders
- Other dental services not shown as covered

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Other Benefits *continued*

Accidental injury benefit (both options)

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. 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 the injury.

High Option—You pay nothing **Standard Option—You pay** 20% of charges

Vision Care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, this Plan provides an annual eye refraction, including a written lens prescription for, but not including, eyeglass lenses.

High Option—You pay a $10 office visit copay per visit.

Standard Option—You pay 20% of charges after a $100 deductible.

For both options, if you use the services of non-Plan doctors in the KPS Service Area, payment will be made to you of up to 75% of the KPS maximum Schedule of Allowances and you will be responsible for the difference between the provider's charges and the Plan's allowance. All applicable copays, deductibles and coinsurance will be applied. No coverage is provided for the services of non-Plan doctors outside the KPS Service Area except for emergencies or referrals.

What is not covered

- Corrective lenses or frames
- Eye exercises; treatment of dyslexia; visual analysis therapy; training related to muscular imbalance of the eye; and orthoptics.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Service Office at 360 / 478-6796 or toll free (in Washington State) 1-800 / 552-7114 or you may write to the Plan at P.O. Box 339, Bremerton, Washington 98337. You may also contact the Plan by fax at 360 / 415-6514, or at its web site at http://www.kpshealthplans.com.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

OPM review (cont.)

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal Court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act Statement—If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How Kitsap Physicians Service Changes January 1999

Do not rely on this page. It is not an official statement of benefits.

Program-wide Changes

- Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.
- As always, this Plan allows direct access (no referral from Primary Care Provider required) to Plan specialists such as gynecologists, cardiologists, oncologists, dermatologists, etc. In 1999, however, you will be required to call the Plan at 1-800-223-6114 for all care related to mental conditions or substance abuse. The Plan will develop a treatment plan with you and your Plan provider that allows an adequate number of direct access visits with a mental health or substance abuse provider, without the need to obtain further referrals. See pages 16-17 for details.
- A medical emergency is defined as 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 (see pages 14-16).
- The diagnosis, evaluation and medical management of certain mental conditions will be covered under the Plan's Medical and Surgical Benefits provision. Examples include attention deficit disorder and Gilles de la Tourette's syndrome. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits.
- The definition of experimental or investigational (see page 7).

Changes to this Plan

- The organ transplant benefit has been clarified to show that all services related to the transplant are paid at 50% after the first $100,000, including any re-transplants within one year of the initial transplant.
- The home health benefit has been clarified to indicate that services of medical social workers are also payable under this benefit.
- The smoking cessation benefit has been split between the limited benefits section and the prescription drug section. Professional services associated with smoking cessation are payable at 50% up to a $150 lifetime maximum, and prescription drugs related to smoking cessation are payable at 50% up to a $350 lifetime maximum.
- The Plan now includes a limited sleep apnea benefit which is payable at 50% up to a lifetime maximum of $8,000 per member.
- The Plan now provides coverage for drugs to treat impotence (when determined by the Plan to be medically necessary) to an annual maximum Plan payment of $500 per member.
- The outpatient office visit limits associated with mental health and substance abuse benefits have been removed. However you or your Plan doctor must contact the Plan at 1-800-223-6114 to authorize all mental health or substance abuse services.
- Massage therapy is an excluded service.
- For Standard Option only, in addition to preventive dental care, the Plan now provides basic dental care.