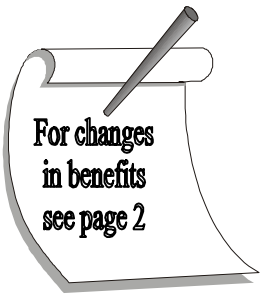
KPS Health Plans 2000

Formerly Kitsap Physicians Service

A Prepaid Comprehensive Medical Plan



Serving: Kitsap, Mason and Jefferson Counties in Northwestern Washington
Enrollment in this Plan is limited; see page 3 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 Retirement and Insurance

Federal Employees Health Benefits Program

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Table of Contents

Introduction

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

This brochure describes the benefits you can receive from KPS Health Plans under its contract (CS1767) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 2. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to KPS Health Plans as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. **Health Maintenance Organizations (HMO).** This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work. This Plan is also a Comprehensive Individual-practice Prepaid Medical Plan. Turn to this section for a brief description of Comprehensive Individual-practice Prepaid Medical Plans and how they work.
2. **How we change for 2000.** If you are a current member and want to see how we have changed, read this section.
3. **How to get benefits.** Make sure you read this section; it tells you how to get services and how we operate.
4. **What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. **General exclusions – Things we don't cover.** Look here to see benefits that we will not provide.
7. **Limitations – Rules that affect your benefits.** This section describes limits that can affect your benefits.
8. **FEHB facts.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Comprehensive Individual-practice Prepaid Medical Plans

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

Section 2. How we change for 2000

Program-wide changes

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition or are in the second or third trimester of pregnancy, and your specialist provider leaves the Plan for reasons other than for cause, you may continue to see your specialist provider for up to 90 days (or until the end of your postpartum care). You have similar rights if this Plan leaves the FEHB program. (See Section 3, How to get benefits, for more information).

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- Your share of the Standard Option KPS Health Plans premium will increase by 10.0% for Self Only and 10.0% for Self and Family.
- Your share of the High Option KPS Health Plans premium will decrease by 17.1% for Self Only and 18.3% for Self and Family.
- The chemotherapy, radiation and inhalation benefit has been split between the Medical and Surgical Benefits section and the Prescription Drug Benefit section. The professional services are covered under the Medical and Surgical Benefits. Self-administered drugs are covered under the Prescription Drug Benefit.
- The durable medical equipment benefit is now limited to a maximum Plan payment of $2,500 per member per year and a lifetime maximum of $50,000 per member.
- Cardiac rehabilitation for stable angina pectoris is provided for up to a maximum Plan payment of $500.
- Ambulance transportation has been clarified to indicate that it will be covered when it is medically necessary. Air ambulance transportation is limited to $5,000 per trip.
- The Prescription Drug Benefit has been clarified to indicate that prescription drugs must be medically necessary to be covered. Drugs that are not medically necessary will not be covered.
- Compounded hormone replacement therapy is an excluded drug.
- Drugs designated by the Pharmacy and Therapeutic Committee are excluded.
- The Plan now includes full mouth x-rays once every 5 years and an emergency examination when determined necessary by the Plan.
- We have clarified that crowns are not a covered dental benefit.
- Sound natural teeth are defined as those that do not have any restorations.

Section 3. How to get benefits

What is this Plan's service area

To enroll with us, you must live in our service area. This is where our providers practice. Our service area is: the counties of Jefferson, Kitsap, and Mason in Northwest Washington.

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

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area, you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas.

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

How much do I pay for services?

You must share the cost of some services. This is called either a deductible (the amount you must pay each year before the Plan starts paying benefits) a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services, except for emergency care.

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

Annual Deductible

High Option – Each family member must pay a deductible of $600 per year for the Prescription Drug Benefit.

Standard Option – You must pay a deductible of $100 for one family member or $200 for two or more family member. This deductible is waived for accidental injuries.

Copayments and Coinsurance

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.

Standard Option -- After you pay $2,000 in coinsurance for one family member, or $2,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs, dental services, or services for which your 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 cessation costs, and costs for outpatient treatment of mental conditions/substance abuse*)* do not count toward these limits and you must continue to make these payments.

What If I have Medicare Part B as my Primary coverage?

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.

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

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

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

Section 3. How to get benefits (continued)

Who provides my health care? (continued)

The Plan arranges with doctors (579 primary care physicians 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 Plan doctor of your choice who will arrange for coordination of your medical care and for referrals to other providers (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.

What do I do if my primary care doctor leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan doctor. If you need to be hospitalized, your primary care doctor or specialist will make the necessary hospital arrangements (including Plan authorization) and supervise your care. Under the Mental Conditions inpatient benefit, if your hospitalization extends from one year to the next and reaches or exceeds the covered benefit of 30 days, you must be discharged before the new year's benefit of 30 days becomes available.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 360/ 478-6796. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

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

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care doctor will arrange your referral to a specialist

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

What do I do if I am seeing a specialist when I enroll?

Your primary care doctor will decide what treatment you need. If they decide 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.

What do I do if my 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 for up to 90 days, or until we can make arrangements for you to see someone else.

Section 3. How to get benefits (continued)

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your doctor must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

How do you decide if a service is experimental or investigational?

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 postmarketing approval clinical trials, and devices classified by the FDA as "Category B Non-experimental/Investigational Devices" are not considered experimental or investigational.

Section 4. What to do if we deny your claim or request for service

If we deny services or your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

Section 4. What to do if we deny your claim or request for service (continued)

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us (360/478-6796) and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively you can call OPM's health benefits Contract Division II at (202) 606-3818 between 8 a.m. and 5 p.m. (Eastern Standard Time). Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. 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 us about the claim;
3. Copies of all letters we sent you about the claim; and
4. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

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 this procedure performed on an inpatient basis and remain in the hospital 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 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 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:

Pre-admission certification authorizes inpatient hospital benefits and is valid for six months. Approval for each admission or re-admission is required. The Plan will provide coverage only for the number of hospital days which have been pre-certified. 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. 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 judgement 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.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Benefits (continued)

Medical and Surgical Benefits (continued)

What is Covered (continued)

The following services are included:

- Preventive care, including well-baby care and periodic check-ups (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.
- Mastectomy benefits include: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prosthesis; and treatment of physical complications of mastectomy, including lymphedemas. 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. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy. All self-administered drugs will be administered through the Prescription Drug Benefit.
- 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 are provided up to a maximum Plan payment of $2,500 per year and a lifetime maximum of $50,000.
- 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 (and approved by the Plan), 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.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Benefits (continued)

Medical and Surgical Benefits (continued)

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 page 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, medical and surgical treatment and hospitalization 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, myocardial infarction or in cases of stable angina pectoris, 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 dietitian 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.

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**.**

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Benefits (continued)

Medical and Surgical Benefits (continued)

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

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.

Hospital care

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

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 and when medically necessary. Air ambulance benefits are limited to $5,000 per trip. If, however, 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.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Benefits (continued)

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.

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.

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 a $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.

Section 5. Benefits (continued)

Emergency Benefits (continued)

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 $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 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 5-6.

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.

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 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 appropriated 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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Benefits (continued)

Mental Conditions/Substance Abuse Benefits (continued)

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 that are medically necessary 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 medically necessary) to an annual maximum Plan payment of $500 per member
- Oral and injectable contraceptive drugs; contraceptive diaphragms; intrauterine devices (IUDs); implanted time released contraceptives such as Norplant.
- 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. This benefit is not subject to the deductible.

What is not covered

- Drugs available without a prescription or for which there is a 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
- Drugs for the treatment of infertility
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Benefits (continued)

Prescription Drug Benefits (continued)

What is not covered (continued)

- Implanted time-release medications (except those used for contraception, 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).
- 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.

Other Benefits

Dental care

What is covered (Standard Option only)

The following preventive and diagnostic dental services are covered when provided by Plan dentists. No deductible is required. **You pay** 20% of charges.

Preventive dental care

Diagnostic
Full mouth 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

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. **You pay** 20% of charges.

Restorative
Restoration of carious (decayed) teeth to a state of functional accepta-bility utilizing filling materials, such as amalgam, silicate or plastic.

Application of sealants for permanent molars and bicuspids only (with a 3 year limitation per surface) to age 14.

Oral Surgery
Removal of teeth and minor surgical procedures, including surgical and non-surgical extractions, preparation of the alveolar ridge and soft tissues of the mouth for insertion of dentures and general anesthesia when administered in connection with covered oral surgery procedures.

Periodontics
Surgical and non-surgical procedures for treatment of the tissues supporting the teeth, including root planning, subgingival curettage, gingivectomy and minor adjustments to occlusion such as smoothing ofteeth 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.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Benefits (continued)

Other Benefits (continued)

Dental care (continued)

What is not covered

- Appliances or restorations necessary to correct vertical dimensions or restore the occlusion are not covered
- Crowns 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 planning 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 nightguards, 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

Accidental injury benefit (both options)

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

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 the Plan determines it is medically necessary to prevent, diagnose, or treat your illness or condition.

We do not cover the following:

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

Section 7. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

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.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833.

Section 7. Limitations – Rules that affect your benefits (continued)

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

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

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

If you have a malpractice claim

If you have a malpractice claim because of services you did or did not receive from a plan provider, it must go to binding arbitration. Contact us about how to begin our binding arbitration process.

Section 8. FEHB Facts

You have a right to information about your Plan.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 360/478-6796, or write to KPS Health Plans, 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.

Where do I get information about enrolling in the FEHB Program?

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

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

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.

When are my benefits and premiums effective?

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

What happens when I 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, which is described later in this section.

What types of coverage are available for me and my 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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Are my medical and claims records 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,
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions,
- OPM and the General Accounting Office when conducting audits,
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

Section 8. FEHB Facts (continued)

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

We will not refuse to cover the treatment of a condition that you or a family member have solely because you had the condition before you enrolled.

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse 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 more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Section 8. FEHB Facts (continued)

How do I enroll in TCC? (continued)

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

How can I get a Certificate of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.
If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

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
U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person 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.

Summary of Benefits for KPS Health Plans -- 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure).

ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.

Benefits	High Option pays/provides	Page	Standard Option pays/provides	Page
Inpatient care	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity**. You pay $200 per admission**	10	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity**. You pay** 20% of charges*	10
Extended care	All necessary services, no dollar or day limit**,** You pay **nothing**	10	All necessary services, no dollar or day limit, **You pay** 20% of charges*	10
Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year**.** You pay **nothing**	12	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year**. You pay** 20% of charges*****	12
Substance abuse	Each member is entitled to rehabilitative benefits of $5,000 per 24-month period	13	Each member is entitled to rehabilitative benefits of $5,000 per 24-month period	13
Outpatient care	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay per office visit; a $15 copay per home visit	7-8	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations (not subject to deductible); laboratory tests and X-rays; complete maternity care. **You pay** 20% of charges*	7-8
Home health care	Services by nurses, health aides**,** and medical social workers. **You pay** nothing	7-8	Services by nurses, health aides**,** and medical social workers. **You pay** 20% of charges*	7-8
Mental conditions	No visit limits if you access care through the Managed Mental Health Program. **You pay** 50% of charges	12	No visit limits if you access care through the Managed Mental Health Program. **You pay** 50% of charges	12
Substance abuse	No visit limits if you access care through the Managed Substance Abuse Program. **You pay** 50% of charges	13	No visit limits if you access care through the Managed Substance Abuse Program. **You pay** 50% of charges	13
Emergency care	Reasonable charges for services and supplies required because of a medical emergency. **You pay** $25 copay for each emergency room visit and any charges for services that are not covered benefits of this plan	11-12	Reasonable charges for services and supplies required because of medical emergency. **You pay** 20% and charges for each emergency room visit and any charges for services that are not covered benefits of this Plan*	11-12
Prescription drugs	Drugs prescribed by a Plan doctor, when filled at a Plan pharmacy. **You pay** 50% of costs after meeting a $600 calendar year deductible	13-14	Drugs prescribed by a Plan doctor, when filled at a Plan pharmacy. **You pay** 20% of charges	13-14
Dental care	Accidental injury benefit. **You pay** nothing	15	Accidental injury benefit: **you pay** 20% of charges. Preventive dental care: **you pay** 20% of charges, no deductible required. Basic dental care: **you pay** 20% of charges after a $25 deductible.	14-15
Vision care	One refraction annually. **You pay** a $10 copay per office visit	15	One refraction annually. **You pay** 20% of charges*	15
Out-of-pocket maximum	Copayments are required for a few benefits. However, the Plan has established a maximum amount of $600 per member per calendar year for hospital copayments	3	In addition to the deductible, coinsurance is required for most benefits. 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 costs of prescription drugs or dental services ***These benefits are subject to a $100 per member per year deductible (maximum of two deductibles per Self and Family enrollment).**	3

2000 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 most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Kitsap/Mason/Jefferson Counties									
High Option Self Only	**VT1**	**$78.83**	**$71.28**	**$170.80**	**$154.44**	**$93.06**	**$57.05**	**$93.26**	**$56.85**
High Option Self and Family	**VT2**	**$175.97**	**$145.11**	**$381.27**	**$314.40**	**$207.74**	**$113.34**	**$201.02**	**$120.06**
Kitsap/Mason/Jefferson Counties									
Standard Option Self Only	**VT4**	**$77.57**	**$25.86**	**$168.08**	**$56.02**	**$91.79**	**$11.64**	**$91.79**	**$11.64**
Standard Option Self and Family	**VT5**	**$169.51**	**$56.50**	**$367.27**	**$122.42**	**$200.58**	**$25.43**	**$200.58**	**$25.43**