Kaiser Foundation Health Plan of Georgia, Inc.

http://kp.org/feds

Member Services 1-888-865-5813

2016

A Health Maintenance Organization (High and Standard Options)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

Serving: *Atlanta, Georgia metropolitan area and Athens, Columbus, Macon and Savannah service areas*

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 13
- Summary of benefits: Page 96

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 12 for requirements.

This Plan has excellent accreditation from the NCQA.

Enrollment codes for this Plan:

F81 High Option – Self Only
F83 High Option - Self Plus One
F82 High Option – Self and Family

F84 Standard Option – Self Only
F86 Standard Option - Self Plus One
F85 Standard Option - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from Kaiser Foundation Health Plan of Georgia, Inc.
About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Kaiser Foundation Health Plan of Georgia, Inc. prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all Plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of Kaiser Foundation Health Plan of Georgia, Inc. under our contract (CS 2163) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. If you want more information about us, you can call Member Services Department at 404-261-2590 (locally in the metropolitan Atlanta area) or 1-888-865-5813 (long distance) (TTY: 711). The address for Kaiser Foundation Health Plan of Georgia, Inc.'s administrative offices is:

Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, Georgia 30305-1736

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 13 . Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples.

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

Stop Health Care Fraud!

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

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

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

- Do not give your Plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOB) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 404-261-2590 (TTY: 711) and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter a Plan hospital for a covered service, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen. These conditions and errors are called "Never Events" (See Section 10, Definitions of terms we use in this brochure). When a Never Event occurs you may not incur cost sharing. If you are charged a cost share for a never event that occurs at a Plan provider while you are receiving an inpatient covered service, or for treatment to correct a never event that occurred at a Plan provider, please notify the Plan.

You may no longer be billed a cost share at Plan providers for inpatient covered services related to never events and treatment needed to correct never events, if you use Kaiser Permanente providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

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

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

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

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

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

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 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 or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus one or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2016 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2015 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you, or a family member, are no longer eligible to use your health insurance coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

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

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

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

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

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this Plan works

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

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

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

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

Questions regarding what protections apply may be directed to us at 404-261-2590 (locally in the metropolitan Atlanta area) or 1-888-865-5813 (long distance). You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our High and Standard Options

Our HMO offers both a High and Standard Option. Under our High Option there are not any deductibles and you pay a copayment for most of your covered services. Under our Standard Option there are deductibles and many of the covered services are subject to coinsurance.

How we pay providers

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

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, our providers, and our facilities. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- We are a health maintenance organization that has provided health care services to Georgia since 1985.
- This medical benefit plan is provided by Kaiser Foundation Health Plan of Georgia, Inc. Medical and hospital services are provided through our integrated health care delivery organization known as Kaiser Permanente. Kaiser Permanente is composed of Kaiser Foundation Health Plan of Georgia, Inc. (a not-for-profit organization) and The Southeast Permanente Medical Group, Inc. (a for-profit Georgia-based corporation) which provides services in Plan medical offices throughout Georgia and also through participating providers.
- If you want more information about us, call 404-261-2590 (TTY: 711), or write to Kaiser Foundation Health Plan of Georgia, Inc., Member Services Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736. You may also contact us by visiting our website at http://kp.org/feds.

Your medical and claims records are confidential

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

Language Interpretation Services

Language interpretation services are available to non-English speaking members. Please ask an English speaking friend or relative to call our Member Services Department at 404-261-2590 (locally in the metropolitan Atlanta area) or 1-888-865-5813 (long distance) (TTY: 711).

Service Area

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

Atlanta metro service area: Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton.

Athens service area: Clarke, Madison, Oconee, and Oglethorpe.

Columbus service area: Chattahoochee, Harris, Marion, and Muscogee County.

Macon service area : Bibb, Bleckley, Crawford, Houston, Jones, Laurens, Monroe, Peach, Pulaski, and Twiggs County.

Savannah service area: Bryan, Bulloch, Chatham, Effingham, Evans and Liberty County.

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente or allied plan service area, you can receive visiting member care from designated providers in that area. See Section 5(h), *Special features*, for more details. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described in Section 5(h); and for emergency care obtained from any non-Plan provider, as described in Section 5(d), *Emergency services/accidents*. We will not pay for any other health care services.

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

Section 2. Changes for 2016

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

Program-wide changes

- Self Plus One enrollment type has been added effective January 1, 2016.

Changes to High Option only

- Your share of the non-Postal premium will increase for Self Only and decrease for Self and Family. See page 98.
- We have decreased your copayment for pediatric primary care office visits from $15 per visit to no charge. See page 26.
- We have added a cost share for specialty drugs at 20% up to a $100 when obtained at a Plan medical office or Plan participating community pharmacy. See page 61.

Changes to Standard Option only

- Your share of the non-Postal premium will increase for Self Only or for Self and Family. See page 98.
- We have decreased your copayment for pediatric primary care office visits from $20 to no charge. See page 26.
- We have added coverage for chiropractic care at $35 per office visit up to 20 visits per calendar year. See page 39.
- We have reduced the cost share for anesthesia during female voluntary sterilization from 20% of our allowance after the deductible to no charge. See page 41.
- We have increased your cost share for non-preferred brand name drugs from $40 to $50 when obtained at a Plan medical office pharmacy; and $60 when obtained from a Plan community pharmacy; we have added a cost share for specialty drugs at 30% up to a $150 when obtained at a Plan medical office or Plan participating community pharmacy. See page 61.

Changes to both High and Standard Options

- We have reduced the cost share to no charge for services as required by the Affordable Care Act, including screening for Hepatitis B virus for persons at high risk, the application of fluoride varnish for children under the age of 5, and low-dose aspirin for women at risk for preeclampsia. See page 27.
- We have removed the 90-day limit on visiting member care when temporarily visiting a Kaiser Foundation Health Plan or allied plan service area. See page 66.
- We have removed pediatric preventive dental services as applying to the catastrophic protection out-of-pocket maximum. See page 22.
- We have added coverage for Residential Treatment Center services for the treatment of mental health. See page 58.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call Member Services at 404-261-2590 (locally in the metropolitan Atlanta area) or 1-888-865-5813 (long distance), (TTY: 711), or write to us at: Member Services Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736. After registering on our website at http://kp.org/feds, you may also request replacement cards electronically.

Where you get covered care

You get care from "Plan providers" and "Plan facilities". You will only pay cost-sharing as defined in Section 10, *Definitions of terms we use in this brochure*.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We contract with The Southeast Permanente Medical Group, Inc. (Medical Group) to provide or arrange covered services for our members. Medical care is provided through physicians, nurse practitioners, physician assistants, and other skilled medical personnel. Specialists in most major specialties are available as part of the medical teams for consultation and treatment. Other necessary medical care, such as physical therapy, laboratory and X-ray services, is also available. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. Directories are available at the time of enrollment or upon request by calling our Member Services Department at (404) 261-2590 (locally) or 1-888-865-5813 (long distance) (TTY: 711). The list is also on our website at http://kp.org/feds.

- **Plan facilities**

Plan facilities are hospitals, medical offices, and other facilities in our service area that we own or contract with to provide covered services to our members. Kaiser Permanente offers comprehensive health care at Plan facilities conveniently located throughout our service areas.

We list Plan facilities in the provider directory, 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 our Member Services Department at (404) 261-2590 (locally) or 1-888-865-5813 (long distance)(TTY: 711). The list is also on our website at http://kp.org/feds.

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

What you must do to get covered care

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

To choose or change your primary care physician, you can either select one from our Provider Directory, from our website, http://kp.org/feds, or you can call our Member Services Department at 404-261-2590 (locally in the metropolitan Atlanta area) or 1-888-865-5813 (long distance) (TTY: 711).

- **Primary care**

We encourage you to choose a Medical Group physician as your primary care physician when you enroll. If you do not select a primary care physician, one will be selected for you. You may choose any primary care Plan physician who is available to accept you. Parents may choose a pediatrician as the Plan physician for their child. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

Please notify us of the primary care physician you choose. If you need help choosing a primary care physician, call us or visit our website at http://kp.org/feds. You may change your primary care physician at any time. You are free to see other Plan physicians if your primary care physician is not available, and to receive care at other Kaiser Permanente facilities.

- **Specialty care**

Specialty care is care you receive from providers other than a primary care physician. When your primary care physician believes you may need specialty care, he or she will request authorization from the Plan to refer you to a specialist for an initial consultation and/or for a certain number of visits. If the Plan approves the referral, you may seek the initial consultation from the specialist to whom you were referred. You must then return to your primary care physician after the consultation, unless your referral authorizes a certain number of additional visits without the need to obtain another referral. The primary care physician must provide or obtain authorization for a specialist to provide all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral that has been approved by us. However, you may see Plan gynecologists, obstetricians, dermatologists, optometrists, ophthalmologists, mental health and substance abuse providers and any specialist in the Medical Group without a referral. You may make appointments directly with these providers.

Here are some other things you should know about specialty care:

- Keep in mind that your primary care physician choice determines which specialists are available to you. Your primary care physician has an established relationship with a specific group of specialty care doctors. By referring only to a certain group of specialists, your primary care physician is better able to ensure that you receive quality care.
- If you change primary care physicians, you must check with your new primary care physician to determine if you can continue seeing your current specialist or if you need a new referral.
- If you receive specialty care services outside the Medical Group for which a referral was not obtained, is no longer valid or is beyond the level of care authorized by us, you will be responsible for all charges associated with those services.
- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician in consultation with you and your attending specialist may 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 (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive approved services from your current specialist until we can make arrangements for you to see a Plan specialist.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for a reason other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or
  - reduce our service area and you enroll in another FEHB plan

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

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

- **Hospital care**

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services Department immediately at 404-261-2590 (TTY: 711). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

- **Rescheduling of services**

Copayments, deductibles and coinsurance for services are due at the time of your visit. We reserve the right to reschedule non-urgent care if you do not pay at the time of your visit.

You need prior Plan approval for certain services

For certain services your Plan provider must obtain approval from us. Before giving approval, we may consider if the service or item is medically necessary and meets other coverage requirements. We call this review and approval process "preauthorization".

When you receive medical services for which you do not have preauthorization from us, we will not pay for them except in an emergency. Charges for these medical services will be your financial responsibility.

Your Plan provider must obtain preauthorization from us for:

- Inpatient hospital care services, surgery and procedures
- Outpatient surgery, related services and procedures
- Ambulance transport (non-emergency)

- Bariatric surgery and related services
- Transgender surgical services
- Clinical trials
- Dental services covered under the medical plan and temporomandibular joint treatment
- The following diagnostic services:
  - Sleep studies
  - Neuropsychological testing
  - Video capsule endoscopy
- Durable medical equipment (DME) and orthopedic and prosthetic devices
- Feeding disorder treatment
- Growth hormone therapy (GHT)
- Home health services and hospice care
- Infertility diagnosis and treatment
- Injections/infusions
- Organ/tissue transplants and related services
- Outpatient multidisciplinary rehabilitation
- Post-stabilization care
- Speech therapy
- The following radiology services:
  - CT scans
  - CT angiography
  - MRI
  - MRA
  - PET
  - SPECT
  - Specialty imaging
- Skilled nursing care
- The following treatment therapies:
  - Biofeedback
  - Hyperbaric oxygen (HBO) treatment
  - Pain management services
  - Sclerotherapy or other varicose vein treatment
  - Uterine artery embolization
- Wound care services
- Services or items from a non-Plan provider or at non-Plan facilities

To confirm if your service or item requires preauthorization, please call our Member Services Department at 404-261-2590 (TTY: 711).

Your Plan provider submits the request for the services above with supporting documentation. You should call your Plan provider's office if you have not been notified of the outcome of the review within 5 working days. If your request is not approved, you have the right to ask us in writing to reconsider our initial decision (see Section 8, *The disputed claims process*).

Preauthorization determinations are made based on the information available at the time the service or item is requested. We will not cover the service or item unless you are a Plan member on the date you receive the service or item.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 404-261-2590 (locally or 1-888-865-5813 (long distance)(TTY: 711). You may also call OPM's Health Insurance 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 404-261-2590 (locally or 1-888-865-5813 (long distance)(TTY: 711). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency services/ accidents and post-stabilization care**

  Emergency services do not require preauthorization. However, if you are admitted to a facility, you or your family member must notify the Plan within 48 hours, or as soon as reasonably possible, or your claims may be denied.

  You must obtain preauthorization from us for post-stabilization care you receive from non-Plan providers.

  See Section 5(d), *Emergency services/accidents* for more information.

- **If your treatment needs to be extended**

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules

If you or your Plan physician do not obtain prior authorization from us for services or items that require prior authorization, we will not pay any amount for those services or items and you may be liable for the full price of those services or items. This also includes any residual amounts, such as deductibles, copayments or coinsurance, that are not covered or not paid by any other insurance plan you use to pay for those services or items.

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our prior approval decision, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

  Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to do one of the following:

  1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply.

  2. Ask you or your provider for more information.

  You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

  If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written request for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM** — After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your cost for covered services

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

Cost-sharing

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

Copayments

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

You pay a primary care provider copayment when you visit any primary care provider as described in Section 3, *How you get care*. You pay a specialist copayment when you receive care from a specialist as described in Section 3.

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

- Under the High Option Plan, you pay a $15 copayment when you receive diagnostic and treatment services from a primary care provider and a $30 copayment when you receive these services from a specialty care provider.
- Under the Standard Option Plan, you pay a $20 copayment when you receive diagnostic and treatment services from a primary care provider and a $35 copayment when you receive these services from a specialty care provider.

Deductible

High Option Plan:

We do not have a deductible in the High Option Plan.

Standard Option Plan:

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. You do not have to satisfy the deductible before we start paying for any service or supply for which you pay a copayment. However, copayments do not accrue toward the deductible. Certain other benefits, including but not limited to infertility, also do not accrue to the deductible.

The calendar year deductible for the Standard Option Plan is $250 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined per person covered expenses applied to the calendar year deductible for family members reach $500.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Any payment you make toward the deductible for services you receive during the last three months of a calendar year will also apply toward the deductible for the next calendar year.

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

Coinsurance

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

Example: In our High and Standard Option Plans, you pay 50% of our allowance for infertility services and 20% of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum

After your cost-sharing total is $3,500 per person up to $7,000 per family enrollment in any calendar year, you do not have to pay any more for certain covered services. This includes any services required by group health plans to count toward the catastrophic protection out-of-pocket maximum by federal health care reform legislation (the Affordable Care Act and implementing regulations).

Example: Your plan has a $3,500 per person up to $7,000 per family maximum out-of-pocket limit. If you or one of your covered family members has out-of-pocket qualified medical expenses of $3,500 in a calendar year, any cost-sharing for qualified medical expenses for that individual will be covered fully by your health plan for the remainder of the calendar year. With a family enrollment, the out-of-pocket maximum will be satisfied once two or more family members have out-of-pocket qualified medical expenses of $7.000 in a calendar year, and any cost–sharing for qualified medical expenses for all enrolled family members will be covered fully by your health plan for the reminder of the calendar year.

However, copayments and coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Chiropractic services
- Dental services
- Health education services
- Hearing aids
- Infertility services
- Travel benefit
- Payments for services under the Student Out-of-Area Coverage

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

Carryover

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

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

When Government facilities bill us

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

Section 5. High and Standard Option Benefits

See page 13 for how our benefits changed this year. Page 96 and page 97 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Standard Option Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 404-261-2590 (TTY: 711) or on our website at http://kp.org/feds.

Since 1985, Kaiser Permanente of Georgia has offered quality integrated health care to the communities we serve. As part of our continued commitment to keep pace with your healthcare needs, we have enhanced our care management programs to include “Whole Person” health coaching. Members can now enjoy one-on-one health coaching, in addition to having access to the Southeast Permanente Medical Group, Inc. and affiliated private practice physicians.

Our delivery system offers convenient, comprehensive care all under one roof. You can come to many of our medical facilities and see a primary care physician, pediatrician, Ob/Gyn, and other specialists, fill prescriptions, have mammograms, complete lab work, get x-rays and more.

Also, our sophisticated health technology gives you the opportunity, 24 hours a day and 7 days a week, to schedule appointments, send secure messages to your provider, refill prescriptions, research medical conditions and view your medical information on line.

For 2015-2016, Kaiser Permanente's Commercial HMO and Medicare HMO received "Excellent Accreditation” - the highest level of accreditation possible - from the National Committee for Quality Assurance (NCQA), a private, non-profit organization dedicated to improving health care quality.

This Plan offers two options: the High and Standard Options. Both options are designed to include preventive and acute care services provided by our Plan providers. The options offer different levels of benefits and services for you to choose between to best fit your health care needs.

Each option offers unique features.

High Option

Our High Option provides the most comprehensive benefits. There is no calendar year deductible. You pay a copayment for most covered services. You get high quality, personalized care with The Southeast Permanente Medical Group, Inc. and affiliated private practice physicians on both the High and Standard Options.

Standard Option

With the Standard Option there is a calendar year deductible of $250 per person ($500 per Self Plus One or Self and Family) and your copayments and coinsurance may be higher than for the High Option, however your bi-weekly premium is lower.

Additional Benefits – Dental

Please note, with either Kaiser Permanente Plan option you automatically receive preventive dental plan benefits as described in Section 5(g), administered by Delta Dental, Inc. For more extensive dental benefits you may also choose the voluntary comprehensive dental benefits through the DeltaCare USA Dental Program, administered by Delta Dental Insurance Company as described in Section 5, Non-FEHB benefits available to Plan members.

Please review this brochure carefully to learn which of our Kaiser Foundation Health Plan of Georgia FEHB options is best for you. If you would like more information about our benefits please contact us at 404-261-2590 (TTY: 711) or visit our website at http://kp.org/feds.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copayment applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Under Standard Option - The calendar year deductible is $250 per person ($500 per family enrollment). The calendar year deductible and Plan coinsurance apply to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Under High Option – We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Different copayments apply for primary care visits and specialty care visits in the Standard and High Option Plans. Please refer to Section 10, Definitions, to learn more about when your primary and specialty care copayments will apply.
- YOU MUST GET PREAUTHORIZATION FOR SOME MEDICAL PROCEDURES. Please refer to the preauthorization list shown in Section 3 to be sure which services and supplies require preauthorization.

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians and other health care professionals • In physician's office • Office medical consultations • Second surgical opinion	$15 per primary care office visit (nothing for children through age 17) $30 per specialty care office visit	$20 per primary care office visit (nothing for children through age 17) $35 per specialty care office visit (No deductible)
Professional services of physicians and other health care professionals • To receive injections	$15 per primary care office visit $30 per specialty care office visit	$20 per primary care office visit $35 per specialty care office visit (No deductible)
• During a hospital stay • In a skilled nursing facility	Nothing	20% of our allowance after you have met your calendar year deductible
Certain procedures received during an office visit, such as: • Cardiac stress tests • Nerve conduction studies	Nothing	$35 per office visit (No deductible)

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
At home	Nothing	Nothing (No deductible)
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing	Nothing (No deductible)
• CT scans/MRI • Nuclear medicine • PET scans	$30 per office visit	20% of our allowance after you have met your calendar year deductible
Preventive care, adult	**High Option**	**Standard Option**
One routine physical exam per calendar year	Nothing	Nothing (No deductible)
Routine screenings, such as: • Total blood cholesterol • Colorectal cancer screening, including - Fecal occult blood test - Sigmoidoscopy screening - every five years starting at age 50	Nothing	Nothing (No deductible)
• Colorectal cancer screening, including - Colonoscopy screening – every ten years starting at age 50	Nothing	Nothing (No deductible)
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing (No deductible)
Well woman care including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling	Nothing	Nothing (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Screening and counseling for interpersonal and domestic violence	Nothing	Nothing (No deductible)
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing	Nothing (No deductible)
Ovarian cancer surveillance test for women age 35 and older or at risk	Nothing	Nothing (No deductible)
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing	Nothing (No deductible)
Preventive services required to be covered by group health plans at no cost share by federal health care reform legislation (the Affordable Care Act and implementing regulations). Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-aand-b-recommendations/ and HHS at www.healthcare.gov/preventive-care-benefits/	Nothing	Nothing (No deductible)
Notes: • You should consult with your physician to determine what is appropriate for you. • You pay cost-sharing for diagnostic and treatment services for illness or injury received during a preventive care exam. See Section 5(a), *Diagnostic and treatment services*.		
Not covered: • *Physical exams and immunizations required for:* - *Obtaining or continuing employment'* - *Insurance or licensing* - *Attending schools, sports or camp* - *Participating in employee programs* - *Court ordered parole or probation* - *Travel*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Preventive care, children	**High Option**	**Standard Option**
• Well-child care, including routine examinations and immunizations (through age 17)	Nothing	Nothing (No deductible)
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing (No deductible)
Examinations, such as: - Eye exam through age 17 to determine the need for vision correction - Hearing screening through age 17 to determine the need for hearing correction Note: Hearing screenings are provided by a primary care physician as part of a well-child care visit. For other hearing exams or tests, see Section 5(a), *Diagnostic and treatment services* or Section 5(a), *Hearing services*.	Nothing	Nothing (No deductible)
Preventive services required to be covered by group health plans at no cost share by federal health care reform legislation (the Affordable Care Act and implementing regulations). Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-aand-b-recommendations/ and HHS at www.healthcare.gov/preventive-care-benefits/	Nothing	Nothing (No deductible)
Note: Should you receive services for an illness, injury or condition during a preventive care examination, you may be charged the cost-share for professional services in a physician's office. See Section 5(a), *Diagnostic and treatment services*.		
Not covered: • *Physical exams and immunizations required for:* - *Obtaining or continuing employment'* - *Insurance or licensing* - *Attending schools, sports or camp* - *Participating in employee programs* - *Court ordered parole or probation* - *Travel* • *All other hearing testing, except as may be covered in Section 5(a), Diagnostic and treatment services and Section 5(a), Hearing services*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Routine prenatal care visits • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • First post postpartum care visit	Nothing	Nothing (No deductible)
• All other visits during pregnancy (such as visits to genetics counselors and perinatologists)	$30 per office visit	$35 per office visit (No deductible)
• Delivery	Nothing for inpatient professional delivery services	20% or our allowance after you have met your calendar deductible
Notes: • Routine maternity care is covered after confirmation of pregnancy. • You do not need prior approval for your normal delivery. See Section 3, *You need prior Plan approval for certain services*, for prior approval guidelines. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • You pay cost-sharing for other services, including: - Diagnostic and treatment services for illness or injury received during a non-routine maternity care as described in this section - Lab, X-ray and other diagnostic tests (including ultrasounds), Durable medical equipment (including breastfeeding pumps) as described in this section - Surgical services (including circumcision of an infant if performed at the mother's discharge from the hospital) as described in Section 5(b). *Outpatient hospital or ambulatory surgical center* - Hospitalization (including delivery) as described in Section 5(c). *Inpatient hospital*		

Benefit Description	You pay After the calendar year deductible...	
Family planning	**High Option**	**Standard Option**
A range of family planning services for women, limited to: • Female voluntary sterilization (See Section 5(b), *Surgery benefits*) • Surgically implanted contraceptive drugs • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Family planning counseling • Contraceptives counseling Notes: • We cover oral contraceptive drugs, diaphragms and cervical caps under Prescription drug benefits. See Section 5(f). • For surgical costs associated with family planning, See Section 5(b), *Surgery benefits*. • Male family planning services are covered in Primary and Specialty office visits. See Section 5(a), *Diagnostic and treatment services*.	Nothing	Nothing (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis of infertility	$30 per office visit	$35 per office visit (No deductible)
Treatment of infertility, such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Semen analysis • Hysterosalpingogram • Hormone evaluation Notes: • See Section 5(f), *Prescription drug benefits*, for coverage of fertility drugs. • Infertility is the inability of an individual to conceive or produce conception during a period of 1 year if the female is age 35 or younger, or during a period of 6 months if the female is over the age of 35.	50% of our allowance	50% of our allowance (No deductible)

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Infertility services (cont.)	**High Option**	**Standard Option**
• Infertility services are covered for individuals over the age of 18 who meet medically necessary criteria and are authorized by the Plan. See Section 3, *You need prior Plan approval for certain services*, for more information. • A Plan physician will determine the appropriate treatment and number of attempts for infertility treatment.	50% of our allowance	50% of our allowance (No deductible)
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Assisted reproductive technology (ART) procedures, including related services and supplies, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Sperm and eggs (whether from a member or from a donor) and services and supplies related to their procurement and storage, including freezing* • *Ovum transplants* • *Infertility services when either member of the family has been voluntarily surgically sterilized.* • *Services to reverse voluntary, surgically induced infertility*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$30 per office visit	$35 per office visit (No deductible)
• Injections	$15 per primary care office visit $30 per specialty care office visit	$20 per primary care office visit $35 per specialty care office visit (No deductible)
• Serum	Nothing	Nothing (No deductible)
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants in Section 5(b).	$30 per office visit	$35 per office visit (No deductible)
• Respiratory and inhalation therapy • Dialysis - hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) Note: Growth hormone requires our prior approval and is covered under the prescription drug benefit. See Section 3, *You need prior Plan approval for certain services* and Section 5(f), *Prescription drug benefits.*	$30 per office visit	$35 per office visit (No deductible)
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing at home $30 per office visit	Nothing at home $35 per office visit (No deductible)
Not covered: • *Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered under Section 5(b), Organ/Tissue transplants.*	*All charges*	*All charges*
Physical and occupational therapies	**High Option**	**Standard Option**
Up to 20 visits per condition per calendar year for: - Physical habilitative and rehabilitative therapy by qualified physical therapists to attain or restore bodily function when you have a total or partial loss of bodily function due to illness or injury - Occupational habilitative and rehabilitative therapy by occupational therapists to assist you in attaining or resuming self-care and improved functioning in other activities of daily life when you have a total or partial loss of bodily function due to illness or injury. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 weeks or 36 visits, whichever comes first.	$30 per outpatient visit Nothing per visit during covered inpatient admission	20% of our allowance after you have met your calendar year deductible
Physical therapy for the prevention of falls as required to be covered by group health plans at no cost share by federal health care reform legislation (the Affordable Care Act and implementing regulations). Includes: • Balance/gait training • Endurance/strength training	Nothing	Nothing (No deductible)

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
• Comprehensive outpatient rehabilitation facility services	Nothing	20% of our allowance after you have met your calendar year deductible
Not covered: • *Long-term therapy* • *Exercise programs* • *Maintenance therapy* • *Cognitive rehabilitation programs, except in cases of traumatic brain injury* • *Vocational rehabilitation programs* • *Therapies done primarily for educational purposes* • *Services provided by local, state and federal government agencies, including schools*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Habilitative and rehabilitative services for up to 20 visits per condition per calendar year	$30 per outpatient office visit Nothing per visit during covered inpatient admission	20% of our allowance after you have met your calendar year deductible
Not covered: • *Long-term speech therapy* • *Therapies done primarily for educational purposes* • *Therapy for tongue thrust in the absence of swallowing problems* • *Training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation* • *Voice therapy for occupation or performing arts* • *Services provided by local, state, and federal government agencies including schools*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing aids, including testing and examinations for them, for children through age 17 Notes: For coverage of: • Hearing screenings, see Section 5(a), Preventive care, children and, for any other hearing testing, see Section 5(a), Diagnostic and treatment services. • Audible prescription reading and speech generating devices, see Section 5(a), Durable medical equipment.	All charges in excess of $1,000 for each hearing impaired ear every 36 months	All charges in excess of $1,000 for each hearing impaired ear every 36 months (No deductible)

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

Benefit Description	You pay After the calendar year deductible...	
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
Not covered: • All other hearing testing, except as may be covered in Section 5(a), Diagnostic and treatment services and Section 5(a), Preventive care, children • Hearing aids, including testing and examinations for them, for all persons age 18 and over	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Diagnosis and treatment of diseases of the eye • Routine eye exam with a Plan optometrist to determine the need for vision correction and provide a prescription for eyeglasses	$30 per office visit	$35 per office visit (No deductible)
Not covered: • *Eyeglasses and frames* • *Contact lenses, examinations for contact lenses or the fitting of contact lenses* • *Eye surgery solely for the purpose of correcting refractive defects of the eye* • *Vision therapy, including orthoptics, visual training and eye exercises* • *Low vision aids*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$15 per primary care office visit $30 per specialty care office visit	$20 per primary care office visit $35 per specialty care office visit (No deductible)
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
External prosthetic and orthotic devices, such as: • Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Ostomy and urological supplies • Therapeutic shoes required for conditions associated with diabetes • Braces • Scoliosis braces	20% of our allowance	20% of our allowance after you have met your calendar year deductible
Internal prosthetic devices, such as: • Artificial joints • Pacemakers • Cochlear implants • Surgically implanted breast implants following mastectomy • Intraocular implant following cataract removal Note: See 5(b), *Surgery benefits*, for coverage of the surgery to insert the device and Section 5(c), *Hospital benefits*, for inpatient hospital benefits.	Nothing	Nothing (No deductible)
Notes: • Orthopedic and prosthetic equipment or services must be prescribed by a Plan physician; obtained through sources designated by the Plan; consistent with Medicare guidelines; and primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury. • We cover only those standard items that are adequate to meet the medical needs of the member. • For coverage of hearing aids, see Section 5(a), Hearing services.		
Not covered: • *Orthopedic and prosthetic devices and corrective shoes, except as described above* • *Foot orthotics and podiatric use devices, such as arch supports, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Dental prostheses, devices, and appliances*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• *Repairs, adjustments, or replacements due to misuse or loss*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option. Covered items include: • Oxygen and oxygen dispensing equipment • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Speech generating devices • Blood glucose monitors • Insulin pumps • Infant apnea monitors Notes: • We only provide DME in the Plan's service area. • We cover only those standard items that are adequate to meet the medical needs of the member. • We may require you to return the equipment to us, or pay us the fair market price of the equipment, when it is no longer prescribed. • Durable medical equipment (DME) is equipment that is prescribed a Plan physician; obtained through sources designated by the Plan; consistent with our Plan DME formulary guidelines; intended for repeated use; primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury; designed for prolonged use; and appropriate for use in the home.	20% of our allowance	20% of our allowance after you have met your calendar year deductible
• Breastfeeding pumps, including any equipment that is required for pump functionality	Nothing	Nothing (No deductible)
Not covered: • *Audible prescription reading devices* • *Comfort, convenience or luxury equipment or features* • *Non-medical items such as sauna baths or elevators* • *Exercise and hygiene equipment* • *Electronic monitors of the heart, lungs, or other bodily functions, except for infant apnea monitors* • *Devices to perform medical testing of bodily fluids, excretions or substances* • *Modifications to the home or vehicle*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• *Dental appliances* • *More than one piece of durable medical equipment serving essentially the same function* • *Spare or alternate use equipment* • *Disposable supplies* • *Replacement batteries* • *Repairs, adjustments, or replacements due to misuse or loss*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), home health aide, physical or occupational therapist, and speech and language pathologist. • Services include oxygen therapy, intravenous therapy and medications. Notes: • We only provide these services in the Plan's service areas. • These services are covered only if you are homebound and a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home.	Nothing	Nothing (No deductible)
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Custodial care* • *Private duty nursing* • *Personal care and hygiene items* • *Care that a Plan provider determines may be appropriately provided in a Plan facility, hospital, skilled nursing facility or other facility we designate and we provide, or offer to provide, that care in one of these facilities*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Chiropractic	**High Option**	**Standard Option**
Up to 20 visits per calendar year, limited to: • Diagnosis and treatment of neuromusculoskeletal disorders • Laboratory tests, pathology and plain film X-rays associated with diagnosis and treatment (not to exceed 4 views) • Adjunctive therapies such as ultrasound, electrical muscle stimulation, and vibratory therapy, not to exceed 2 per visit Notes: • You may only self-refer to a participating chiropractor. The participating chiropractor must provide, arrange or prescribe your care. • For a list of participating chiropractors, contact our Member Services Department at 404-261-2590 (TTY: 711).	$30 per office visit	$35 per office visit (No deductible)
Not covered: • *Hypnotherapy, behavior training, sleep therapy and weight programs* • *Thermography* • *Any radiological exam other than plain film studies such as magnetic resonance imaging, CT scans, bone scans, nuclear radiology* • *Treatment for non-neuromusculoskeletal disorders* • *Chiropractic appliances, except as covered in Section 5(a), Durable medical equipment and Prosthetics and orthotic devices*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
Not covered, including acupuncture	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Health education classes, including: • Stress reduction • Chronic conditions, such as diabetes and asthma	$15 per office visit	$20 per office visit (No deductible)
• Tobacco cessation programs, including individual, group and telephone counseling	Nothing	Nothing (No deductible)
• General health education not addressed to a specific condition, as well as Lamaze classes and weight control	Charges vary	Charges vary (No deductible)
• Childhood obesity education	Nothing - $10/program	Nothing - $10/program (No deductible)
Notes: • Please call Member Services at 404-261-2590 for information on cost and classes near you.		

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• You pay nothing for over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. See Section 5(f), *Prescription drug benefits*, for important information about coverage of tobacco cessation and other drugs. • You can also participate in programs that are available through Kaiser Permanente as non-FEHB benefits. These programs may require that you pay a fee. See the end of Section 5, *Non-FEHB benefits available to Plan members.*		

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. Consult with your physician to determine what is appropriate for you. Services may be covered provided that established Plan physicians' criteria are met.
- Under Standard Option - The calendar year deductible is $250 per person ($500 per family enrollment). The calendar year deductible and Plan coinsurance apply to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Under High Option – We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES**. Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Transgender surgical services, limited to genital surgery and mastectomy to treat gender dysphoria • Correction of congenital anomalies (see *Reconstructive surgery*)	$30 per visit with specialist Nothing for hospital or ambulatory surgical center physician and professional services See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) 20% of our allowance for outpatient and inpatient surgery and procedures after you have met your calendar year deductible See Section 5(c) for facility charges

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Surgical treatment of morbid obesity (bariatric surgery). You must: - be 18 years of age or older; and - have a Body Mass Index (BMI) greater than 40; or a BMI greater than 35 with another severe or life threatening condition such as: sleep apnea, cardiomyopathy or severe diabetes; and - have weight control failure; and - have made a commitment to a long term weight management plan and a behavioral health and nutrition assessment; and - have no untreated metabolic cause of obesity Notes: • You will need to meet the above qualifications before your Plan provider will refer you to our bariatric surgery program. This program may refer you to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including: - nutritional, - psychological, - medical; and - social readiness for surgery. • Final approval for surgical treatment will be required from The Southeast Permanente Medical Group's designated physician. See Section 3, *You need prior Plan approval for certain services*, for more information.	$30 per visit with specialist Nothing for hospital or ambulatory surgical center physician and professional services See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) 20% of our allowance for outpatient and inpatient surgery and procedures after you have met your calendar year deductible See Section 5(c) for facility charges
• Insertion of internal prosthetic devices. See 5(a), *Orthopedic and prosthetic devices,* for device coverage information • Male voluntary sterilization (e.g., vasectomy) • Treatment of burns Notes: • Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$30 per visit with specialist Nothing for hospital or ambulatory surgical center physician and professional services See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) 20% of our allowance for outpatient and inpatient surgery and procedures after you have met your calendar year deductible See Section 5(c) for facility charges
• Female voluntary sterilization, including anesthesia and a hysterosalpingogram following tubal occlusion • Surgically implanted time-released contraceptives and insertion of intrauterine devices (IUDs)	Nothing	Nothing (No deductible)

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Surgical procedures (cont.)	**High Option**	**Standard Option**
Notes: • We cover the cost of these surgically implanted time-release contraceptive drugs and intrauterine devices under the prescription drug benefit (see Section 5(f)).	Nothing	Nothing (No deductible)
Not covered: • *Reversal of voluntary sterilization* • *Services for the promotion, prevention, or other treatment of hair loss or hair growth* • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form* • *Transgender surgical services, other than genital surgery and mastectomy*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • Surgery for treatment of a form of congenital hemangioma known as port wine stains on the face of members 18 years or younger • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery and reconstruction on the other breast to produce a symmetrical appearance; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$30 per visit with specialist Nothing for hospital or ambulatory surgical center physician and professional services See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) 20% of our allowance for outpatient and inpatient surgery and procedures after you have met your calendar year deductible See Section 5(c) for facility charges

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Medical and surgical treatment of temporomandibular joint (TMJ) disorder (non-dental); and • Other surgical procedures that do not involve the teeth or their supporting structures, except extraction of the teeth to prepare the jaw for radiation treatment of neoplastic disease.	$30 per visit with specialist Nothing for hospital or ambulatory surgical center physician and professional services See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) 20% of our allowance for outpatient and inpatient surgery and procedures after you have met your calendar year deductible See Section 5(c) for facility charges
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Shortening of the mandible or maxillae for cosmetic purposes* • *Correction of any malocclusion not listed above* • *Dental services associated with medical treatment such as surgery, except for services related to accidental injury of teeth (See Section 5(g))*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. Refer to Section 3, *How you get care* for preauthorization procedures. Solid organ tissue transplants are limited to: • Cornea • Heart • Heart/Lung • Intestinal transplants - Isolated Small intestine	$30 per visit with specialist Nothing for inpatient surgery See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) Nothing for inpatient surgery See Section 5(c) for facility charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney/Pancreas • Liver • Lung: Single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	$30 per visit with specialist Nothing for inpatient surgery See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) Nothing for inpatient surgery See Section 5(c) for facility charges
The following blood or marrow stem cell transplants are not subject to medical necessity review. Our denial is limited to the cytogenetics, subtype or staging of the diagnosis (e.g. acute, chronic) as appropriate for the diagnosis. Blood or marrow stem cell transplants are limited to: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed)	$30 per visit with specialist Nothing for inpatient surgery See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) Nothing for inpatient surgery See Section 5(c) for facility charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Amyloidosis - Neuroblastoma	$30 per visit with specialist Nothing for inpatient surgery See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) Nothing for inpatient surgery See Section 5(c) for facility charges
The following blood or marrow stem cell transplants are not subject to medical necessity review. Blood or marrow stem cell transplants for: • Allogeneic transplants for: - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for: - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors	$30 per visit with specialist Nothing for inpatient surgery See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) Nothing for inpatient surgery See Section 5(c) for facility charges
Limited benefits - The following autologous blood or bone marrow stem cell transplants may be provided in a National Cancer Institute (NCI) or National Institutes of Health (NIH)-approved clinical trial at a Plan-designated Center of Excellence. These limited benefits are not subject to medical necessity. • Advanced Childhood kidney cancers • Advanced Ewing sarcoma • Aggressive non-Hodgkin's lymphomas • Childhood rhabdomyosarcoma • Epithelial ovarian cancer • Mantle Cell (Non-Hodgkin's lymphoma)	$30 per visit with specialist Nothing for hospital or ambulatory surgical center physician and professional services See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) 20% of our allowance for outpatient and inpatient surgery and procedures after you have met your calendar year deductible See Section 5(c) for facility charges
Mini-transplants performed in a Clinical Trial Setting (non-myeloblative, reduced intensity conditioning for member over 60 years of age). • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis	$30 per visit with specialist Nothing for inpatient surgery See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) Nothing for inpatient surgery See Section 5(c) for facility charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	$30 per visit with specialist Nothing for inpatient surgery See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) Nothing for inpatient surgery See Section 5(c) for facility charges
Tandem transplants: Subject to medical necessity • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$30 per visit with specialist Nothing for inpatient surgery See Section 5(c) for facility charges	$35 per visit with specialist (No deductible) Nothing for inpatient surgery See Section 5(c) for facility charges
Notes: • We cover related medical and hospital expenses of the donor when we cover the recipient. • We cover donor screening tests for potential donors for solid organ transplants. We cover human leukocyte antigen (HLA) typing for potential donors for a bone marrow/stem cell transplant only for parents, children and siblings of the recipient. • We cover computerized national and international search expenses for prospective unrelated bone marrow/stem cell transplant donors conducted through the National Marrow Donor Program, and the testing of blood relatives of the recipient. • Please refer to Section 5(h), *Special features,* for information on our Centers of Excellence.		

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Not covered: • *Donor screening tests and donor search expenses, except those listed above* • *Implants of non-human artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	20% of our allowance after you have met your calendar year deductible

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Under Standard Option – The calendar year deductible is $250 per person ($500 per family enrollment). The calendar year deductible and Plan coinsurance apply to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Under High Option – We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR ALL NON-EMERGENCY INPATIENT HOSPITAL CARE SERVICES (except for maternity stays).** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$250 per day up to $750 per admission	$250 per day up to $1,000 per admission (No deductible)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	$250 per day up to $750 per admission	$250 per day up to $1,000 per admission (No deductible)

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The need for anesthesia, by itself, is not such a condition.	$250 per day up to $750 per admission	$250 per day up to $1,000 per admission (No deductible)
• Medical supplies and equipment, including oxygen, and any covered items billed by a hospital for use at home	According to the benefit of the specific item you take home (i.e., hospital bed, pharmacy items, etc.)	According to the benefit of the specific item you take home (i.e., hospital bed, pharmacy items, etc.)
Not covered: • *Custodial care and care in an intermediate care facility* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, and guest meals and beds* • *Private nursing care, except when medically necessary* • *Inpatient dental procedures* • *Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Lab, X-ray, and other diagnostic tests • Blood and blood products • Pre-surgical testing • Dressings, casts, and sterile trays • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. See Section 5 (h) for dental information.	$150 per visit	20% of our allowance after you have met your calendar year deductible
Not covered: • *Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Skilled nursing care facility benefits	**High Option**	**Standard Option**
Up to 100 days per calendar year when you need full-time nursing care. All necessary services are covered, including: • Room and board • General nursing care • Medical social services • Prescribed drugs, biologicals, supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility	Nothing	Nothing (No deductible)
Not covered: • *Custodial care and care in an intermediate care facility* • *Personal comfort items, such as telephone, television, barber services, and guest meals and beds*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Supportive and palliative care for a terminally ill member: • You must reside in the service area • Services are provided in the home, when a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home. Services include inpatient care under limited circumstances, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less. Note: Hospice is a program for caring for the terminally ill patient that emphasizes supportive services, such as home care and pain and symptom control, rather than curative care. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, therapy services for purposes of safety and symptom control, physician services, palliative drugs in accord with our drug formulary guidelines, durable medical equipment (DME), and short-term inpatient care for pain control and acute and chronic symptom management. We also provide inpatient respite care, counseling and bereavement services. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.	Nothing	Nothing (No deductible)
Not covered: • *Independent nursing (private duty nursing)* • *Homemaker services*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Ambulance	**High Option**	**Standard Option**
• Local licensed ambulance service when medically necessary Note: See Section 5(d) for emergency services	$100 per trip	$125 per trip (No deductible)
Not covered: • *Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider*	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under Standard Option - The calendar year deductible is $250 per person ($500 per family enrollment). The calendar year deductible and Plan coinsurance do not apply to benefits in this Section.
- Under High Option – We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

If you have a medical emergency, dial 911 or go to the nearest emergency room.

Emergencies within our service area:

Emergency care is provided at Plan hospitals 24 hours a day, seven days a week. The location and phone number of your nearest Plan hospital may be found in your FEHBP Facility Guide.

If you think you have a medical emergency condition and you cannot safely go to a Plan hospital, call 911 or go to the nearest hospital. 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 must notify the Plan within 24 hours, unless it was not reasonably possible to do so.

If you need to be hospitalized, the Plan must be notified within 24 hours or as soon as reasonably possible. If you are hospitalized in non-Plan facilities and Plan physicians believe care can be better provided in a Plan hospital, we will transfer you 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. Post stabilization care is the service you receive after your treating physician determines that you are clinically stable. We cover post-stabilization care if a Plan provider provides it or if you obtain authorization from us to receive the care from a non-Plan provider.

To request preauthorization for post-stabilization care from a non-Plan provider, you must call us at (404) 365-0966 (locally) or 1 (800) 611-1811 (long distance or the notification telephone number on your Kaiser Permanente ID card) before you receive the care if it is reasonably possible to do so (otherwise call us as soon as reasonably possible). After we are notified, we will discuss your condition with the non-Plan provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a Plan provider, we will authorize your care from the non-Plan provider only if we cannot arrange to have a Plan provider (or other designated provider) provide the care. If we decide to have a Plan hospital, skilled nursing facility, or designated non-Plan provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

We understand that extraordinary circumstances can delay your ability to call us to request preauthorization for post-stabilization care from a non–Plan provider, for example, if a young child is without a parent or guardian present, or you are unconscious. In these cases, you must call us as soon as reasonably possible. Please keep in mind that anyone can call us for you. We will not pay for any services you receive from non–Plan providers after your emergency medical condition is stabilized unless you obtain preauthorization, so if you don't call as soon as reasonably possible, you will be financially responsible for this post-stabilization care.

When you are sick or injured, you may have an urgent care need. An urgent care need is one that requires prompt medical attention, but is not a medical emergency. If you think you may need urgent care, call the appropriate appointment or advice nurse number at a Plan facility. Please refer to the Guidebook for advice nurse and Plan facility telephone numbers.

Emergencies outside our service area:

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

If you need to be hospitalized, the Plan must be notified within 24 hours or as soon as reasonably possible. If a Plan physician believes care can be better provided in a Plan hospital, then we will transfer you when medically feasible, with any ambulance charges covered in full.

When you are sick or injured, you may have an urgent care need. An urgent care need is one that requires prompt medical attention, but is not a medical emergency. If you think you may need urgent care, call the appropriate appointment or advice nurse number at a Plan facility. Please refer to the Guidebook for advice nurse and Plan facility telephone numbers. If you are temporarily outside the service area and have an urgent care need due to an unforeseen illness or injury, we cover the medically necessary services and supplies you receive from a non-Plan provider if we find that the services and supplies were necessary to prevent serious deterioration of your health and they could not be delayed until you returned to the service area.

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente Plan. The facilities will be listed in the local telephone book under Kaiser Permanente. These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling the Member Services Department in the Atlanta area at 404-261-2590, or from other areas at 1-888-865-5813 (TTY: 711).

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at an urgent care center not designated by the Plan • Emergency care as an outpatient at a hospital, including physicians' services • Urgent care at a Plan emergency room Notes: • We waive your emergency room copayment if you are directly admitted to a hospital as an inpatient from the emergency room. Your inpatient admission copayment will still apply (See Section 5(c)). • Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency copayment will not be waived.	$150 per visit	$175 per visit (No deductible)
• Urgent care at a Plan urgent care center	$30 per office visit	$40 per office visit (No deductible)

Emergency within our service area - continued on next page

Benefit Description	You pay	
Emergency within our service area (cont.)	**High Option**	**Standard Option**
Not covered: • *Elective care or non-emergency care* • *Urgent care at a non-Plan urgent care center or emergency*	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at an urgent care center not designated by the Plan • Emergency care as an outpatient at a hospital, including physicians' services • Urgent care at an emergency room Notes: • We waive your emergency room copayment if you are directly admitted to a hospital from the emergency room. Your inpatient hospital copayment will still apply (See Section 5(c)). • Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency copayment will not be waived. • See Section 5(h) for travel benefit coverage of continuing or follow-up care.	$150 per visit	$175 per visit (No deductible)
• Urgent care at an urgent care center	$30 per office visit	$40 per office visit (No deductible)
Not covered: • *Elective care or non-emergency care* • *Follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *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*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Licensed ambulance service when medically necessary. Notes: • See Section 5(c) for non-emergency service. • Trip means any time an ambulance is summoned on your behalf.	$100 per trip	$125 per trip (No deductible)

Ambulance - continued on next page

Benefit Description	You pay	
Ambulance (cont.)	**High Option**	**Standard Option**
Not covered: • *Trips we determine are not medically necessary* • *Transportation by car, taxi, bus, gurney van, wheelchair van, minivan and any other type of transportation, even if it is the only way to travel to a provider or facility*	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Under Standard Option - The calendar year deductible is $250 per person ($500 per family enrollment). The calendar year deductible and Plan coinsurance apply to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Under High Option - We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR ALL NON-EMERGENCY INPATIENT HOSPITAL SERVICES.**

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option Plan calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Professional services	**High Option**	**Standard Option**
We cover professional services recommended by a Plan mental health or substance abuse provider that are covered services, drugs, and supplies described in this brochure. Notes: • We cover the services only when we determine the care is clinically appropriate to treat your condition. • OPM will generally not order us to pay or provide one clinically appropriate treatment in favor of another.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
• Diagnosis and treatment of psychiatric conditions, mental illness, or disorders. Services include: - Medication evaluation and management	$15 per individual therapy office visit	$20 per individual therapy office visit (No deductible)
- Crisis intervention and stabilization for acute episodes - Treatment and counseling (including group and individual therapy visits)	$15 per individual therapy office visit $7 per group therapy office visit	$20 per individual therapy office visit $10 per group therapy office visit (No deductible)
• Diagnosis and treatment of alcoholism and drug abuse. Services include: - Detoxification (medical management of withdrawal from the substance) - Treatment and counseling (including individual and group therapy visits)	$15 per individual therapy office visit $7 per group therapy office visit	$20 per individual therapy office visit $10 per group therapy office visit (No deductible)

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Professional services (cont.)	**High Option**	**Standard Option**
- Rehabilitative care	$15 per individual therapy office visit $7 per group therapy office visit	$20 per individual therapy office visit $10 per group therapy office visit (No deductible)
• Psychological testing to determine the appropriate psychiatric treatment	$15 per office visit	$20 per office visit (No deductible)
Notes: • You may see a Plan mental health or substance abuse provider for these services without a referral from your primary care physician. See Section 3, *How you get care,* for information about services requiring our prior approval. • Your Plan mental health or substance abuse provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you.		
Diagnostics	**High Option**	**Standard Option**
Diagnosis and treatment of psychiatric conditions, mental illness, or disorders. Services include: • Diagnostic tests	$15 per individual therapy office visit $7 per group therapy office visit	$20 per individual therapy office visit $10 per group therapy office visit (No deductible)
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
• Services provided in a hospital or other facility Note: All inpatient admissions require approval by a Plan mental health or substance abuse physician.	$250 per day up to $750 per admission	$250 per day up to $1,000 per admission for facility services (No deductible) 20% of our allowance after you have met your calendar year deductible for professional physician services
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
• Services in approved alternative care settings such as partial hospitalization, residential treatment, facility based intensive outpatient treatment Note: All hospital alternative services treatment programs require approval by a Plan mental health or substance abuse physician.	$150 per visit	20% of our allowance after you have met your calendar year deductible

Benefit Description	You pay After the calendar year deductible...	
Not covered	**High Option**	**Standard Option**
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Services we have not approved* • *Intelligence, IQ, aptitude ability, learning disorders or interest testing not necessary to determine the appropriate treatment of a psychiatric condition* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* • *Services that are custodial in nature* • *Marital, family or educational services* • *Services rendered or billed by a school or a member of its staff* • *Services provided under a federal, state or local government program* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms*	*All charges*	*All charges*

Section 5(f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on page 61.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year pharmacy deductible.
- Your physician must get preauthorization for certain drugs. Certain prescription drugs require approval prior to dispensing. The list of prescription drugs that require preauthorization is subject to periodic review and modification. If you would like to know if a drug requires preauthorization you may contact our Member Services Department at 404-261-2590.
- Federal law prevents the pharmacy from accepting unused medications
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription?** A licensed Plan provider or licensed dentist must prescribe your medication. We cover prescriptions written by a non-Plan provider or filled at a non-Plan pharmacy only for emergencies or out-of-area urgent care.
- **Where you can obtain them.** You may obtain a first fill of your prescription at a Plan medical office pharmacy or a Plan participating community pharmacy, or by the Plan mail order program for certain maintenance medications, as specified below. All refills of your prescription must be obtained at a Plan medical office pharmacy or through the Plan mail order program only. You can order prescriptions from Kaiser Permanente's network mail-order pharmacy service in the following ways.
  - Call 770-434-2008, option 1;
  - Call 1-888-662-4579;
  - Go to our website at www.kp.org/rxrefill and follow the instructions for refilling prescriptions (the Web can only be used for prescriptions that were originally filled at pharmacies located in Kaiser Permanente Medical Centers).
  - Fill out and send in your request by using one of our mail-order pharmacy envelopes. You can order a supply by calling our Member Services Department at 404-261-2590 (TTY: 711). When you use this method of ordering, you can pay by check or credit card.

Allow at least 5 – 7 business days for the prescription to be filled and delivered to you by mail.

We cover prescriptions written by a non-Plan provider or filled at a non-Plan pharmacy only for covered emergencies as specified in Section 5(d), *Emergency services/accidents.*

Plan members called to active military duty (or members in time of national emergency), who need to obtain prescribed medications, should call a Plan pharmacy.

- **We use a formulary.** The medications included in our drug formulary are chosen by a group of Kaiser Permanente physicians, pharmacists and other Plan providers known as the Pharmacy and Therapeutics Committee. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary based on new information or drugs that become available. We cover non-formulary drugs (those not listed on our drug formulary for your condition) prescribed by a Plan provider if they would otherwise be covered and a Plan provider believes that a non-formulary drug best treats your medical condition; a formulary drug has been ineffective in the treatment of your medical condition; or a formulary drug causes or is reasonably expected to cause a harmful reaction. If you request the non-formulary drug when your Plan provider has prescribed a formulary drug, the non-formulary drug is not covered. However, you may purchase the non-formulary drug from a Plan pharmacy at prices charged to members for non-covered drugs. For more information on our prescription drug FEHB formulary, visit kp.org/formulary or call our Member Services Department at 404-261-2590.

You pay applicable drug cost-sharing based on the tier a drug is in. Our drugs are categorized into four tiers:

- **Tier 1: Generic drugs.** Generic drugs are produced and sold under their generic names after the patent of the brand-name drug expires. Although the price is usually lower, the quality of generic drugs is the same as brand-name drugs. Generic drugs are also just as effective as brand-name drugs. The Food and Drug Administration (FDA) requires that a generic drug contain the same active drug ingredient in the same amount as the brand-name drug.
- **Tier 2: Preferred brand-name drugs.** Brand-name drugs are produced and sold under the original manufacturer's brand name. Preferred brand-name drugs are listed on our drug formulary.
- **Tier 3: Non-preferred brand-name drugs.** Non-preferred brand-name drugs are not listed on our drug formulary.
- **Tier 4: Specialty drugs.** Specialty drugs are high-cost drugs that are on our specialty drug list.

If our allowance for the drug, supply, or supplement is less than the copayment, you will pay the lesser amount. Items can change tier at any time, in accord with formulary guidelines, which may impact the cost-sharing you pay (for example, if a brand-name drug is added to the specialty drug list, you will pay the cost-sharing that applies to drugs on the specialty drug tier, not the cost-sharing for drugs on the brand-name drug tier).

- **These are the dispensing limitations.** We provide up to the lesser of a 30 day supply or the standard prescription amount of prescribed covered drugs and certain supplies dispensed in a Plan pharmacy at one copayment or up to a 90-day supply through our mail order program for two copayments. For example, the standard prescription amount for migraine medications, ophthalmic, otic and topical medications, and for oral and nasal inhalers, and other similarly packaged drugs, is the smallest standard package size available. We cover episodic drugs prescribed to treat sexual dysfunction disorders up to a maximum of 8 doses in an 30-day period or 24 doses in any 90-day period. Most drugs can be mailed from our mail order pharmacy. Some drugs (for example, drugs that are extremely high cost or require special handling) may not be eligible for mailing. Mail order drugs are available only in Georgia. The pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan pharmacy can tell you if a drug you take is one of these drugs).
- **A generic equivalent will be dispensed if it is available**, unless your Plan provider specifically requires a brand-name drug. If you request a brand-name drug on the formulary when your Plan provider has prescribed an approved generic drug, you pay your brand-name drug copayment plus the difference in price between the generic drug and your requested brand-name drug.
- **Why use generic drugs?** Typically generic drugs cost you and us less money than a brand-name drug. Under federal law, generic and brand-name drugs must meet the same standards for safety, purity, strength, and effectiveness.
- **When you do have to file a claim.** You do not need to file a claim when you receive drugs from a Plan pharmacy. You have to file a claim when you receive drugs from a non-Plan pharmacy for a covered emergency as specified in Section 5 (d), *Emergency services/accidents*. For information about how to file a claim, see Section 7, *Filing a claim for covered services*.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician or dentist and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that, by federal law, require a physician's prescription for their purchase, except those listed as *Not covered*. • Insulin • Diabetic supplies, limited to glucose test strips and acetone test tablets • Disposable needles and syringes for the administration of covered medications • Compound drugs	**Plan medical office pharmacy:** $10 for generic drugs, $40 for preferred and non-preferred brand name drugs, and 20% up to $100 for specialty drugs up to a 30 day supply. **Plan participating community pharmacy:**	**Plan medical office pharmacy:** $15 for generic drugs, $40 for preferred brand name drugs, $50 for non-preferred brand name drugs, and 30% up to $150 for specialty drugs up to a 30-day supply **Plan participating community pharmacy:**

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Amino acid-modified products used to treat congenital errors of amino acid metabolism • Immunosuppressant drugs required as a result of a covered transplant • Growth hormone therapy (GHT) - in limited circumstances for treatment of children with Turner's syndrome or classical growth hormone deficiency, only with prior approval by Plan physicians Notes: • You will be charged your applicable generic or brand name drug copayment depending on the compound drug's main ingredient, whether the main ingredient is a generic drug or brand name drug. • A compound drug is one in which two or more drugs or pharmaceutical agents are combined together. We limit coverage to products listed in our drug formulary or when one of the ingredients requires a prescription by law. • Growth hormone requires our prior approval. See Section 3, *Services requiring our prior approval.*	**Plan medical office pharmacy:** $10 for generic drugs, $40 for preferred and non-preferred brand name drugs, and 20% up to $100 for specialty drugs up to a 30 day supply. **Plan participating community pharmacy:** $20 for generic drugs, $50 for preferred and non-preferred brand name drugs and 20% up to $100 for specialty drugs up to a 30-day supply For information about mail order discounts, see "These are the dispensing limitations" in the introduction to Section 5(f)	**Plan medical office pharmacy:** $15 for generic drugs, $40 for preferred brand name drugs, $50 for non-preferred brand name drugs, and 30% up to $150 for specialty drugs up to a 30-day supply **Plan participating community pharmacy:** $25 for generic drugs, $50 for preferred brand name drugs and $60 for non-preferred brand name drugs, 30% up to $150 for specialty drugs up to a 30 day supply For information about mail order discounts, see "These are the dispensing limitations" in the introduction to Section 5(f)
• Intravenous fluids and medications for home use	Nothing	Nothing
Women's contraceptive drugs and devices: • Diaphragms and cervical caps • Oral contraceptive drugs • Implanted time release contraceptive drugs • Injectable contraceptive drugs • Topical contraceptives • Intrauterine devices • Prescribed FDA approved over-the-counter women's contraceptives and devices	Nothing	Nothing
Prescribed medications, including prescribed over-the-counter medications, required to be covered by group health plans at no cost share by federal health care reform (the Affordable Care Act and implementing regulations). These include: • Aspirin to reduce the risk of heart attack • Oral fluoride for children to reduce the risk of tooth decay • Folic acid for women to reduce the risk of birth defects • Iron supplements for children to reduce the risk of anemia	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Vitamin D for adults to reduce the risk of falls • Medication to reduce the risk of breast cancer	Nothing	Nothing
• Fertility drugs for covered infertility treatments • Sexual dysfunction drugs	50% of our allowance	50% of our allowance
• Prescribed tobacco cessation medications, including prescribed overt-the-counter medications, approved by the FDA to treat tobacco dependence	Nothing	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Prescriptions filled at a non-Plan pharmacy, except for out-of-area emergencies as described in Section 5(d), Emergency services/accidents* • *Vitamins, nutrients and food supplements that can be purchased without a prescription, unless they are included in our drug formulary or listed as covered above* • *Nonprescription drugs, including prescription drugs for which there is a nonprescription equivalent available, unless listed as covered above* • *Medical supplies such as dressings and antiseptics, except as listed above* • *Drugs that shorten the duration of the common cold* • *Any requested packaging of drugs other than the dispensing pharmacy's standard packaging* • *Replacement of lost, stolen or damaged prescription drugs and accessories* • *Drugs related to non-covered services* • *Drugs for the promotion, prevention, or other treatment of hair loss or growth* • *Contraceptive devices, except as listed above* • *Infant formulas, except for amino acid-modified products noted above* • *Immunizations and other drugs and supplies needed for travel*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, Coordinating benefits with other coverage.
- You can receive covered Dental benefit services from participating Delta Dental PPO dentists, Delta Dental Premier dentists and non-participating dentists.
- Under the Standard Option - The calendar year deductible is $250 per person ($500 per family enrollment). The calendar year deductible and Plan coinsurance apply to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Under the High Option –We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c), *Hospital benefits*, for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover services to promptly repair (but not replace) a sound, natural tooth. The need for these services must result from an accidental injury and all services must be completed within 365 days of the injury in order to be covered. • damage is due to an accidental injury from trauma to the mouth from violent contact with an external object, • the tooth has not been restored previously, except in a proper manner, and • the tooth has not been weakened by decay, periodontal disease, or other existing dental pathology.	50% of our allowance	50% of our allowance (No deductible)
Not covered: • *Services for conditions caused by an accidental injury occurring before your eligibility date*	*All charges*	*All charges*

Dental benefits

Dental Benefits	You Pay	
Preventive dental	**High Option**	**Standard Option**
Diagnostic and preventive dental services when provided by a Delta Dental PPO dentist, Delta Dental Premier or any licensed dentist: • Routine oral examinations - twice per calendar year • Cleaning (prophylaxis) - twice per calendar year (excluding periodontal prophylaxis) • Topical application of fluoride - twice per calendar year • Bitewing X-rays - twice per calendar year for children through age 17 and once per calendar year for adults age 18 and over • Full mouth series X-rays - once every five years Note: You may choose to receive preventive dental benefits from any licensed dentist. Delta Dental dentists agree to negotiated fee schedules as payment in full, and your coinsurance is based on a dentist's fee schedule. Your out-of-pocket costs may be lower if you choose a Delta Dental PPO dentist, rather than a Delta Premier or non-Delta dentist as well. For a list of Delta Dental PPO or Delta Dental Premier dentists, please call Delta Dental at 1-800-521-2651 or go to www.deltadentalins.com	30% of the dentist's usual and customary fee schedule or the fee actually charged, whichever is less	30% of the dentist's usual and customary fee schedule or the fee actually charged, whichever is less (No deductible)
Other dental benefits	**High Option**	**Standard Option**
Non-surgical treatment of temporomandibular joint (TMJ) disorder, including splints and appliances	50% of our allowance	50% of our allowance (No deductible)
General anesthesia and associated hospital or ambulatory surgery facility charges in conjunction with dental care are covered for members: • 7 years of age or younger • Who are developmentally disabled • Who are not able to have dental care under local anesthesia due to a neurological or medically compromising condition • Who have sustained extensive facial or dental trauma	Nothing See Section 5(c) for facility charges.	20% of our allowance after you have met your calendar year deductible See Section 5(c) for facility charges.
• Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease • Extraction of bony impacted teeth	$150 per office visit	20% of our allowance after you have met your calendar year deductible
Not covered: • *Other dental services not specifically shown as covered*	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
Feature	
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
24 hour advice line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 404-365-0966 (locally in the metropolitan Atlanta area) or 1-800-611-1811 (long distance) (TTY: 711) and talk with a registered nurse who can help assess medical symptoms and provide advice over the phone, when medically appropriate.
Centers of Excellence	The Centers of Excellence program began in 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted “Centers of Excellence” for certain specialized medical procedures. We have developed a nationally contracted network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.
Services for the deaf, hard of hearing or speech impaired	We provide a TTY/text telephone number at: 711. Sign language services are also available.

Feature - continued on next page

Feature	Description
Feature (cont.)	
Services from other Kaiser Permanente or allied plans	When you visit a different Kaiser Foundation Health Plan or allied plan service area, you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered services, copayments and coinsurance described in this FEHB brochure. Please call our Member Services Department at 404-261-2590 or 1-888-865-5813 (TTY: 711) to receive more information about visiting member care, including facility locations in other service areas. Service areas and facilities where you may obtain visiting member care may change at any time.
Tobacco cessation	Kaiser Permanente offers smoking cessation classes as described under Educational classes and programs in Section 5(a). In addition to the classes we also offer the following: • Kaiser Permanente's "Great Start" Quit Line is free and available for pregnant women 24 hours a day. • Free smoking cessation resources are available, including a self-help booklet for pregnant women, as well as brochures for adults and teens. • Bookmark listing of smoking cessation resources • Bi-Annual smoking cessation resource outreach mailings to all identified smokers For more information or to order any of the above materials please call our Member Services Department at 404-261-2590 (TTY: 711).
Student coverage outside the service area	We provide a limited benefit to eligible members who are full-time registered college students (at least 12 credit hours per semester) attending a recognized accredited institution outside Kaiser Permanente's service areas and within the United States. These benefits are in addition to your emergency benefits and will be applied before your travel benefit. • We cover routine, continuing and follow-up medical care. • You pay 20% of the usual and customary charges. • Your benefit is limited to $1,200 each calendar year. • There is no deductible. • You must certify the member's student status annually. • For more information about this benefit call our Member Services Department at 404-261-2590 (TTY: 711). • File claims as shown in Section 7. *The following services are not included in your out-of-area student coverage benefit:* • *Dental services* • *Transplants and transplant follow-up care* • *Services provided outside the United States*

Feature - continued on next page

Feature	Description
Feature (cont.)	
Travel benefit	Kaiser Permanente's travel benefit for Federal employees provides you with outpatient follow-up and/or continuing medical and mental health and substance abuse care when you are temporarily (for example, on a temporary work assignment or attending school) outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency services/accident benefit and include: • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast. • Outpatient continuing care for covered services for conditions diagnosed and treated within the previous 12 months by a Kaiser Permanente health care provider or affiliated Plan provider. Services include dialysis and prescription drug monitoring. You pay $25 for each follow-up or continuing care office visit. This amount will be deducted from the reimbursement we make to you or to the provider. We limit our payment for this travel benefit to no more than $1,200 each calendar year. For more information about this benefit call our Member Services Department at 404-261-2590 (TTY: 711). File claims as shown in Section 7. *The following are a few examples of services not included in your travel benefits coverage:* • *Non-emergency hospitalization* • *Infertility treatments* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* • *Transplants* • *Durable medical equipment (DME)* • *Prescription drugs* • *Home health services*
Rewards	Take steps to improve your well-being by completing the Kaiser Permanente Total Health Assessment and a healthy lifestyle program. FEHB subscribers and their enrolled spouses (age 18 and over) are eligible for the following cash gift card rewards: • $50 for completing a confidential, online, Total Health Assessment (available in English or Spanish). You'll get a picture of your overall health and a customized action plan with tips and resources to improve your well-being. You will also have the option to save a summary of your results to your electronic health record so that you can discuss next steps with your personal physician. • $25 for completing an online healthy lifestyle program of your choice. Personalized and self-paced, they can help you reduce stress, quit smoking, lose weight and more. You can complete as many of these online programs as you would like, but you will only earn a reward for one program completion.

Feature - continued on next page

Feature	Description
Feature (cont.)	
	You must complete the Total Health Assessment and/or a healthy lifestyle program during the calendar year. Rewards will be issued 4-6 weeks after you complete either activity. Visa reward cards expire 12 months from date issued. For more information, please go to www.kp.org/feds or call our HealthWorks customer services at 1-866-300-9867.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all grievances must follow the Plan's guidelines. For additional information contact the Plan at 404-261-2590 (TTY: 711).

The DeltaCare USA Dental Program

We are pleased to offer you and your family comprehensive dental coverage through the DeltaCare USA dental program, administered by Delta Dental Insurance Company. To enroll in this voluntary plan, complete the forms provided with your enrollment materials and return them as described by your benefits administrator. After you have enrolled, you will receive an identification card and an Evidence of Coverage booklet that fully describes your dental benefits. If you have questions, you may contact DeltaCare USA at 1-800-422-4234 to speak to a Customer Service Representative, Monday through Friday between 8 a.m. and 9 p.m. EST. You may also access the Delta Dental website at www.deltadentalins.com.

	Monthly Premium*	**Semi-Annual direct-pay Premiums****
Self Only	$10.96	$65.76
Self & Spouse	$18.81	$112.86
Self & Child	$18.93	$113.58
Self & Two or More	$27.29	$163.74

These premiums are effective January 1, 2016, through December 31, 2016.
* The monthly premium is automatically withdrawn from your checking, savings or credit union account.
** The semi-annual premium payment is paid by you directly to PMI.

SelfWise Program

As a Kaiser Permanente member, you're automatically enrolled in our *SelfWise* Program. *SelfWise* provides access to a variety of complementary health services at a discounted rate including chiropractic care, acupuncture, acupressure, LASIK, massage therapy and vision care. When you show your Kaiser Permanente ID card at Plan participating vision locations, you can receive a 25 percent discount on eyeglasses, a 15 percent discount on regular contact lenses, and a 5 percent discount on disposable contact lenses. The discounts do not apply to the examination for the fitting of contact lenses or to other promotional items. Also included are discounted rates for weight management programs and local participating fitness clubs. *SelfWise* also offers interactive online healthy lifestyle tools; and much more.

Note: This program is available to Kaiser Permanente members and their families. Discounts and services are provided on a fee-for-service basis, do not replace and cannot be combined with any existing benefit, are not covered benefits, and are neither offered nor guaranteed under the contract with the FEHB Program. Kaiser Permanente assumes no responsibility for the arrangement, nature, quality, or outcome of the services. For more information, call 404-261-2590 (TTY: 711).

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusion and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3, *You need prior Plan approval for certain services*.

We do not cover the following:

- When a service is not covered, all services, drugs or supplies related to the non-covered service are excluded from coverage, except services we would otherwise cover to treat complications of the non-covered service
- Fees associated with non-payment (including interest), missed appointments and special billing arrangements.
- Care by non-Plan providers except for authorized referrals, emergencies, travel benefit, or services from other Kaiser Permanente Plans (see Emergency services/accidents)
- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants)
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Services, drugs, or supplies you receive without charge while in active military service
- Services provided or arranged by criminal justice institutions for members confined therein
- Applied Behavior Analysis (ABA)

Section 7. Filing a claim for covered services

This section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on prior Plan approval and pre-service claims procedures (services, drugs, or supplies requiring prior Plan approval), including urgent care claims procedures.

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

You may need to file a claim when you receive a service or item from a non-Plan provider or at a non-Plan facility. This includes services such as out-of-network emergency services, out-of-area urgent care and services covered under the travel benefit. Check with the provider to determine if they can bill us directly. Filing a claim does not guarantee payment. If you need to file the claim, here is the process:

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call our Member Service Call Center at 404-261-2825 (TTY: 711).

When you must file a claim - such as for services you received outside the Plan's service area - submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Kaiser Permanente
Claims Administration
P.O. Box 190849
Atlanta, GA 31119-0849

Deadline for filing your claim

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

Post-Service Claims

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit http://kp.org/feds.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing, Attention: Member Services Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736 or calling 1-888-865-5813.

Our reconsideration will not take in account the initial decision. The review will not be conducted by the same person or his/her subordinate, who made the initial decision.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Kaiser Foundation Health Plan of Georgia, Inc., Attention: Appeals Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

If you do not agree with our decision, you may ask OPM to review it.

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You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim;
- Your daytime phone number and the best time to call; and
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 404-261-2590 (locally in the metropolitan Atlanta area) or 1-888-865-5813 (long distance). We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

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

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. If we are the secondary payor, and you received your services from Plan providers, we may bill the primary carrier.

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

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

- **Medicaid**

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When third parties cause illness or injuries

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

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

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused or is responsible for an injury or illness for which you received covered health care services or benefits ("Services"), you must pay us Charges for those Services. "Charges" are: 1) for Services that we pay the provider on a fee-for-service basis, the payments that we made for the Services; and 2) for all other Services, the charges in the provider's schedule of charges for Services provided to Members less any cost share payments that you made to the provider. Our payments for Services in these circumstances are expressly conditioned on your agreement to comply with this paragraph.

You must also pay us Charges for such Services if you receive or are entitled to receive a recovery from any insurance for an injury or illness alleged to be based on a third party's fault, such as from uninsured or underinsured motorist coverage. You must also pay us Charges for such Services if you receive or are entitled to receive recovery from any Workers' Compensation benefits.

To secure our rights, we will have a lien on the proceeds of any judgment or settlement you or we obtain against a third party. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are entitled under our first-priority lien to be paid Charges for Services even if you are not "made whole" for all of your damages in the recoveries that you receive.

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent. You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must notify us within 30 days of the date you or someone acting on your behalf notifies anyone, including an insurer or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury or illness. You must not take any action that may prejudice our right of recovery.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, that person or entity and any settlement or judgment recovered by that person or entity shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

We have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total of Charges for the relevant Services.

We will reduce our lien pro rata to share in your legal fees and costs under the common fund doctrine. This net lien will not be more than (1) one-third of your total gross recovery from all third-party sources if you engaged an attorney to obtain that recovery; or (2) one-half of such recovery if you did not.

Contact us if you need more information about recovery or subrogation.

Surrogacy Agreements

If you enter into a Surrogacy Agreement, you must reimburse us for covered services you receive related to conception, pregnancy, delivery, or postpartum care in connection with the Surrogacy Agreement, except that the amount you must pay will not exceed the payments or other compensation you and any other payee are entitled to receive under the Surrogacy Agreement. A "Surrogacy Agreement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), in exchange for payment or compensation for being a surrogate. The "Surrogacy Agreement" does not affect your obligation to pay your cost-sharing for services received, but we will credit any such payments toward the amount you must pay us under this paragraph. We will only cover charges incurred for any services when you have legal custody of the baby and when the baby is covered as a family member under your Self Plus One or Self and Family enrollment (the legal parents are financially responsible for any services that the baby receives).

By accepting services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Agreement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Agreement, you must send written notice of the Agreement, a copy of the Agreement, including the names, addresses, and telephone numbers of all parties involved in the Agreement. You must send this information to:

Trover Solutions, Inc.
Kaiser Permanente Georgia Surrogacy Mailbox
9390 Bunsen Parkway
Louisville, KY 40220

You must complete and send us consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Agreements" section and to satisfy those rights.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Agreement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

We will cover routine care costs and may cover some extra care costs not provided by the clinical trial in accordance with Section 5 when Plan physicians provide or arrange for your care. We encourage you to contact us to discuss specific services if you participate in a clinical trial.

- Routine care costs are costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy. We cover routine care costs not provided by the clinical trial.
- Extra care costs are costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We cover some extra care costs not provided by the clinical trial. We encourage you to contact us to discuss coverage for specific services if you participate in a clinical trial.

The Plan does not cover research costs.

- Research costs are costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983). Otherwise, if you are age 65 or older, or under age 65 and disabled, you may be able to buy it. Contact **1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048)** for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You may enroll in a Medicare Advantage plan to get your Medicare Part A and Part B benefits. We offer a Medicare Advantage plan, Kaiser Permanente Senior Advantage for Federal Members. Please review the information about Medicare Advantage plans on page 82.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. This notice is on the first inside page of this brochure. However, when you are enrolled in Kaiser Permanente Senior Advantage for Federal Members, Part D is included in your Plan; no separate premium applies. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at **1-800-772-1213 (TTY: 1-800-325-0778)**.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number **1-800-772-1213 (TTY: 1-800-325-0778)** to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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

- **If you enroll in Medicare Part B**

If you enroll in Medicare Part B, we require you to assign your Medicare Part B benefits to the Plan for its services. Assigning your benefits means you give the Plan written permission to bill Medicare on your behalf for covered services you receive in network. You do not lose any benefits or entitlements as a result of assigning your Medicare Part B benefits.

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

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

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 404-233-3700 (locally in the metropolitan Atlanta area) or 1-800-232-4404 (long distance) (TTY: 711), 8 a.m. to 8 p.m., 7 days a week, or visit our website at http://kp.org/feds.

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

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family member may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at **1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048)** or at www.medicare.gov.

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

  This Plan and our Medicare Advantage plan: We offer a Medicare Advantage plan known as Kaiser Permanente Senior Advantage for Federal Members. Senior Advantage for Federal Members enhances your FEHB coverage by lowering cost-sharing for some services and/or adding benefits. If you have Medicare Parts A and B, or Medicare Part B only, you can enroll in Senior Advantage for Federal Members with no increase to your FEHB or Kaiser Permanente premium. Your enrollment is in addition to your FEHB High Option or Standard Option enrollment; however, your benefits will be provided under the Kaiser Permanente Senior Advantage for Federal Members plan and are subject to all Medicare rules. If you are already a member of Senior Advantage for Federal Members and would like to understand your additional benefits in more detail, please refer to your Senior Advantage for Federal Members Evidence of Coverage. If you are considering enrolling in Senior Advantage for Federal Members, please call us at 404-233-3700 (locally in the metropolitan Atlanta area) or 1-800-232-4404 (long distance) (TTY: 711), 8 a.m. to 8 p.m., 7 days a week, or visit our website at http://kp.org/feds.

  With Kaiser Permanente Senior Advantage for Federal Members, you'll get more coverage, such as lower cost sharing and better benefits. This 2016 benefit summary allows you to make a side-by-side comparison of your choices:

2016 Benefits and Services	**High Option** You pay	**Standard Option** You pay	**Senior Advantage High Option** You pay	**Senior Advantage Standard Option** You pay
Deductible	None	$250	None	$250
Primary care	$15 (No charge for children through age 17)	$20 (No charge for children through age 17)	$0	$10
Specialty care	$30	$35	$20	$25
Outpatient surgery	$150	20%*	$20	20%*
Inpatient hospital care	$250 per day up to $750 per admission	$ 250 per day up to $1,000 per admission	$100 per admission	$250 per day up to $750 per admission
Emergency care	$150	$175	$75	$75
Urgent care	$30	$40	$20	$20
Ambulance	$100	$125	$75	$125
Prescription drugs (up to a 30-day supply at Plan pharmacies)				
- Generic	$10	$15	$5	$10
- Preferred brand	$40	$40	$20	$25
- Non-preferred brand	$40	$50	$40	$50
-Specialty	20% up to $100	30% up to $150	20% up to 100	30% up to 150
Eyeglasses and contact lenses (every 24 months)	Not covered	Not covered	$200 allowance	Not Covered
SilverSneakers® Fitness Program	Not covered	Not covered	$0	$0
Out-of-pocket maximum (2x per family)	$3,500 per person	$3,500 per person	$2,000 per person	$2,500 per person

* You pay the deductible, then cost-sharing.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

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

When we are the primary payor, we process the claim first. If you enroll in another plan's Medicare Part D plan and we are the secondary payor, when you fill your prescription at a Plan pharmacy that is not owned and operated by Kaiser Permanente we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan. Our Kaiser Permanente owned and operated pharmacies will not consider another plan's Medicare Part D benefits. These Kaiser Permanente pharmacies will only provide your FEHB Kaiser Permanente benefits.

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

If you enroll in our Kaiser Permanente Senior Advantage for Federal Members plan, you will get all of the benefits of Medicare Part D plus additional drug benefits covered under your FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 21.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.

Cost-sharing

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

Covered services

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

Custodial care

(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting and taking medicine. (2) Care that can be performed safely and effectively by people whom, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Custodial care that lasts 90 days or more is sometimes known as long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.

Experimental or investigational service

We do not cover a service, supply, item or drug that we consider experimental, except for the limited coverage specified in Section 9, Clinical trials. We consider a service, supply, item or drug to be experimental when the service, supply, item or drug:

(1) has not been approved by the FDA; or

(2) is the subject of a new drug or new device application on file with the FDA; or

(3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or

(4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or

(5) is subject to the approval or review of an Institutional Review Board; or

(6) requires an informed consent that describes the service as experimental or investigational;

We carefully evaluate whether a particular therapy is safe and effective or offers a reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental literature.

Group health coverage Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Health care coverage purchased through membership in an organization is also "group health coverage."

Health care professional A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

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

Never event Certain Hospital Acquired Conditions, as defined by Medicare, including things like wrong-site surgeries, transfusion with the wrong blood type, pressure ulcers (bedsores), falls or trauma, and nosocomial infections (hospital-acquired infections) associated with surgeries or catheters, that are directly related to the provision of an inpatient covered service at a Plan provider.

Our allowance Our allowance is the amount we use to determine our payment and your coinsurance for covered services. We determine our allowance as follows:

- For services and items provided by Kaiser Permanente, the applicable charges in the Plan's schedule of Kaiser Permanente charges for services and items provided to Plan members.
- For services and items for which a provider (other than Kaiser Permanente) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Plan member for the item if a Plan member's benefit plan did not cover the item. This amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy services and items to Plan members, and the pharmacy program's contribution to the net revenue requirements of the Plan.
- For all other services and items, the payments that Kaiser Permanente makes for the services and items, or if Kaiser Permanente subtracts cost-sharing from its payment, the amount the Kaiser Permanente would have paid if it did not subtract cost-sharing.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier Charges for Covered Services out of the payment to the extent of the Covered Services provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or workers' compensation program or insurance policy, as a successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from the carriers health benefits plan.
Us/We	Us and We refer to Kaiser Foundation Health Plan of Georgia, Inc.
You	You refers to the enrollee and each covered family member.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Member Services at 404-261-2590 (locally in the metropolitan Atlanta area) or 1-888-865-5813 (long distance). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important Information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP**), provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose Self Only, Self Plus One, or Self and Family coverage for yourself and any eligible dependents.

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

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA) -** Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan. (Note: This Plan does not currently participate in FSAFEDS paperless reimbursement. You must submit a manual claim to FSAFEDS with supporting documentation for reimbursement.)
- **Limited Expense Health Care FSA (LEX HCFSA**) - Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA) -** Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

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

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY: 1-800-843-3557), or visit www.ltcfeds.com.

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

Notes

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Summary of benefits for the High Option of the Kaiser Foundation Health Plan of Georgia, Inc. - 2016

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$15 per primary care office visit (Nothing for children through age 17) $30 per specialty care office visit	26
Services provided by a hospital:		
• Inpatient	$250 per day up to $750 per admission	49
• Outpatient	$150 per visit	50
Emergency benefits:		
• In-area and Out-of-area	$150 per visit	54
Mental health and substance abuse treatment:	Regular cost-sharing	57
Prescription drugs:		
• Plan medical office pharmacy	$10 generic, $40 preferred and non-preferred brand drugs, 20% up to 100 specialty drugs	61
• Plan participating community pharmacy	$20 generic, $50 preferred and non-preferred brand drugs, 20% up to $100 specialty drugs	61
Vision care:	Exam: $30 per office visit	35
Dental care:	Various copayments based upon procedure rendered.	64
Special features: Flexible benefits option; 24 hour advice line; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Tobacco cessation; Student coverage outside the service area; Travel benefit; Rewards		66
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $3,500 for Self Only enrollment or $7,000 for Self and Family enrollment. Some costs do not count toward this protection.	22

Summary of benefits for the Standard Option of the Kaiser Foundation Health Plan of Georgia, Inc. - 2016

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

Standard Option Benefits	You Pay	Page
Deductibles:		
• Covered services	$250 per person and $500 per family	21
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$20 per primary care office visit (Nothing for children through age 17) $35 per specialty care office visit	26
Services provided by a hospital:		
• Inpatient	$250 per day up to $1,000 per admission	49
• Outpatient	20% coinsurance*	50
Emergency benefits:		
• In-area and Out-of-area	$175 per visit	54
Mental health and substance abuse treatment:	Regular cost-sharing	57
Prescription drugs:		
• Plan medical office pharmacy	$15 generic, $40 preferred brand drugs, $50 non-preferred brand drugs, 30% up to $150 specialty drugs	61
• Plan participating community pharmacy	$25 generic, $50 preferred brand drug, $60 non-preferred brand drug, 30% up to $150 specialty drugs	61
Dental care:	Various copayments based on procedure	64
Vision care:	Refractions: $35 per visit	64
Special features: Flexible benefits option; 24 hour advice line; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Tobacco cessation; Student coverage outside the service area; Travel benefit; Rewards		66
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $3,500 for Self Only enrollment or $7,000 for Self and Family enrollment. Some costs do not count toward this protection.	22

2016 Rate Information for Kaiser Foundation Health Plan of Georgia, Inc.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to United States Postal Service employees.
Postal Category 1 rates apply to career bargaining unit employees.
Postal Category 2 rates apply to career non-bargaining unit employees.

For further assistance, Postal Service employees should call:

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

Postal rates do not apply to non-career Postal employees, Postal retirees, or associate members of any Postal employee organization who are not career Postal employees.

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	F81	$213.37	$73.78	$462.30	$159.86	$61.92	$73.78
High Option Self Plus One	F83	$461.02	$176.49	$998.88	$382.39	$150.88	$176.49
High Option Self and Family	F82	$488.50	$167.67	$1,058.42	$363.28	$140.53	$167.67
Standard Option Self Only	F84	$161.04	$53.68	$348.92	$116.31	$44.55	$53.68
Standard Option Self Plus One	F86	$359.11	$119.70	$778.07	$259.35	$99.35	$119.70
Standard Option Self and Family	F85	$370.37	$123.46	$802.48	$267.49	$102.47	$123.46