2005 KAISER PERMANENTE MEDICARE PLUS PLAN C

SUMMARY OF BENEFITS

Introduction to the Summary of Benefits for Kaiser Permanente Medicare Plus Plan C

Thank you for your interest in Kaiser Permanente Medicare Plus. The staff and physicians of Kaiser Permanente look forward to being a partner in your good health. We know that being as healthy as possible and feeling great gives you the ability to live life to the fullest.

Our plan is offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., a Medicare Cost Managed Care plan. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage"(EOC). Representatives are available Monday through Friday, 7:30 a.m. to 5:30 p.m. at 301-468-6000 or 1-800-777-7902 outside the Washington, DC metropolitan area or 301-879-6380 (TTY).

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare managed care plan, like Kaiser Permanente Medicare Plus. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

How can I compare my options?

You can compare Kaiser Permanente Medicare Plus and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer additional benefits, which may change from year to year.

Where is Kaiser Permanente Medicare Plus available?

The Service Area for this plan includes:

District of Columbia

Maryland: The service area for this plan includes the following cities and counties: Anne Arundel, Baltimore City, Baltimore, Calvert* (partial), Carroll, Charles* (partial), Frederick* (partial), Harford, Howard, Montgomery, and Prince George's.

* Calvert is a partial county consisting of the following zip codes: 20639, 20678, 20689, 20714, 20732, 20736, 20754.

* Charles is a partial county consisting of the following zip codes: 20601, 20602, 20603, 20604, 20612, 20616, 20617, 20637, 20640, 20643, 20646, 20658, 20675, 20677, and 20695.

* Frederick is a partial county consisting of the following zip codes: 21701, 21702, 21703, 21704, 21705, 21709, 21710, 21714, 21716, 21717, 21718, 21754, 21755, 21758, 21759, 21762, 21769, 21770, 21771, 21774, 21775, 21777, 21790, 21792, 21793.

Virginia: The service area for this plan includes the following cities and counties: Alexandria City, Arlington, Fairfax City, Fairfax, Falls Church City, Loudoun, Manassas City, Manassas Park City, and Prince William.

You must live in one of these places to have continued membership in the Plan.

Can I choose my doctors?

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. has formed a network of doctors, specialists, and hospitals. You can use any doctors who are part of our Kaiser Permanente Medicare Plus network. You may also go to doctors who are outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list. Our number is listed at the end of this introduction.

What happens if I go to a doctor who's not in your network?

You can always choose to go to a doctor outside our Medicare Plus network. We may not pay for the services you receive outside of our network. You may have to pay more for the services you receive outside the Medicare Plus network. If you go to a provider outside of Kaiser Permanente Medicare Plus who accepts Medicare patients, your coverage would be the same as Original Medicare. Original Medicare deductibles and coinsurance apply and are your responsibility to pay.

What should I do if I have other insurance in addition to Medicare?

If you have Medicare supplemental insurance that fills gaps in the Original Medicare Plan, you may not need it if you join Kaiser Permanente Medicare Plus. If you drop your supplemental policy, you may not be able to get the same one back. You should check into this carefully before you drop your supplemental policy to make sure you have all of the coverage you need.

What are my protections in this plan?

All health plans in the Medicare program agree to stay with the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare managed care plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for health care coverage in your area and give you information about your right to get Medicare supplemental insurance coverage. You can choose another health plan if one is available, or you can receive care from the Original Medicare Plan.

If Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ever denies your claim or a service, we will explain our decision to you. You always have the right to appeal and ask us to review the claim or service that was denied. If a decision is not made in your favor, your appeal will be reviewed by an independent organization that works for Medicare.

Please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. for more information about this plan. Current and prospective members should call Member Services Department, Monday through Friday, 7:30 a.m. to 5:30 p.m. on 301-468-6000 or 1-800-777-7902 outside the Washington, DC metropolitan area or 301-879-6380 (TTY). Please call Medicare at 1-800-633-4227 or visit www.medicare.gov for more information about Medicare. (TTY/TDD # 1-877-486-2048). If you have special needs, this document may be available in other formats.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage" (KFHP-DCCOST-EOC (01/05); or KFHP-MDCOST-EOC (01/05); or KFHP-VACOST-EOC (01/05)). If you have any questions about this plan's benefits or costs, please contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Monday through Friday from 7:30 a.m. until 5:30 p.m. at (301) 468-6000 or 1-800-777-7902 outside the Washington, DC metro calling area. People who have difficulty with hearing or speaking may call our TTY number, 301-879-6380. The TTY number requires special telephone equipment.

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
1 – Doctor and hospital choice (For more information, see Emergency – #9, and Urgently Needed Care – #10.)	
In Network: You must go to Kaiser Permanente network doctors, specialists, and hospitals. You need a referral to go to Kaiser Permanente network hospitals and certain doctors, including specialists. A Visitor/Travel program is available. Ask Kaiser Permanente Medicare Plus for details. **Out-of-Network if you have both Medicare Parts A&B:** If you go to a provider outside of Kaiser Permanente Medicare Plus who accepts Medicare patients, your coverage will be the same as Original Medicare. Original Medicare deductibles and coinsurance apply and will be your responsibility to pay. **Out-of-Network if you have Medicare Part B Only:** If you receive Medicare-covered Part B services from a provider outside of Kaiser Permanente Medicare Plus who accepts Medicare patients, your coverage would be the same as Original Medicare Part B. Original Medicare Part B deductibles and coinsurance apply and are your responsibility to pay.	You may go to any doctor, specialist or hospital that accepts Medicare.

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
2 – Inpatient hospital care (Includes substance abuse and rehabilitation services)	
You pay nothing per benefit period[3] for a Medicare-covered stay in a network hospital.[5] You are covered for unlimited days each benefit period.[3]	**If you have both Medicare Parts A&B:** You pay for each benefit period[3]: **Days 1-60:** an initial deductible of $876 (This is the 2004 amount and may change January 1, 2005.) **Days 61-90:** $219 each day (This is the 2004 amount and may change January 1, 2005.) **Days 91-150:** $438 each lifetime reserve day[4] (This is the 2004 amount and may change January 1, 2005.) Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.[4] **If you have Medicare Part B Only:** In general, you pay 100%.
3 – Doctor office visits	
You pay $5 for each primary care doctor office visit for Medicare-covered services. You pay $5 for each specialist visit for Medicare-covered services.[5] See 33– Routine physical exams for more information.	You pay 20% of Medicare-approved amounts.[1][2]

(1) Each year, you pay a total of one $110 deductible.
(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.
(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the applicable inpatient hospital copayment or deductible for each benefit period. There is no limit to the number of benefit periods you can have.
(4) Lifetime reserve days can only be used once.
(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/ Utilization Review.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage" (KFHP-DCCOST-EOC (01/05); or KFHP-MDCOST-EOC (01/05); or KFHP-VACOST-EOC (01/05)). If you have any questions about this plan's benefits or costs, please contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Monday through Friday from 7:30 a.m. until 5:30 p.m. at (301) 468-6000 or 1-800-777-7902 outside the Washington, DC metro calling area. People who have difficulty with hearing or speaking may call our TTY number, 301-879-6380. The TTY number requires special telephone equipment.

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
4 – Diagnostic tests, x-rays and lab services	
You pay nothing for x-ray visits.[5] You pay nothing for each Medicare-covered clinical/ diagnostic lab service.[5] You pay $5 per visit for each Medicare-covered radiation therapy service.[5]	You pay 20% of Medicare-approved amounts, except for approved lab services.[1][2] There is no copayment for Medicare-approved lab services.
5 – Medicare-covered drugs	
There is no annual maximum benefit limit on Medicare-covered drugs. **Kaiser Permanente Mail Order Program:** You pay $3 for up to a 60-day supply of generic or brand name drugs **Kaiser Permanente Medical Center Pharmacy:** You pay $5 for up to a 60-day supply of generic or brand name drugs **Kaiser Permanente Affiliated Network Pharmacy:** You pay $10 for up to a 60-day supply of generic or brand name drugs	You pay 20% of Medicare-approved amounts.[1][2]

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
6 – Outpatient prescription drugs (Drugs that are not covered by Original Medicare.)	
There is no annual maximum benefit limit on outpatient prescription drugs. You must use a designated Kaiser Permanente Mail Order Program, Kaiser Permanente Medical Center Pharmacy, or Kaiser Permanente Affiliated Network Pharmacy to get your prescription drugs. **Kaiser Permanente Mail Order Program:** You pay $3 for up to a 60-day supply of generic or brand name drugs **Kaiser Permanente Medical Center Pharmacy:** You pay $5 for up to a 60-day supply of generic or brand name drugs **Kaiser Permanente Affiliated Network Pharmacy:** You pay $10 for up to a 60-day supply of generic or brand name drugs Authorization may be required for prescription drugs. When you want higher cost drugs, even though lower cost drugs are available, ask Kaiser Permanente for details on costs and what is covered.	You pay 100% for most prescription drugs.

(1) Each year, you pay a total of one $110 deductible.
(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.
(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the applicable inpatient hospital copayment or deductible for each benefit period. There is no limit to the number of benefit periods you can have.
(4) Lifetime reserve days can only be used once.
(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/ Utilization Review.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage" (KFHP-DCCOST-EOC (01/05); or KFHP-MDCOST-EOC (01/05); or KFHP-VACOST-EOC (01/05)). If you have any questions about this plan's benefits or costs, please contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Monday through Friday from 7:30 a.m. until 5:30 p.m. at (301) 468-6000 or 1-800-777-7902 outside the Washington, DC metro calling area. People who have difficulty with hearing or speaking may call our TTY number, 301-879-6380. The TTY number requires special telephone equipment.

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
7 – Outpatient prescription maintenance medications (Drugs and accessories prescribed for a chronic medical condition expected to last six (6) months or longer.).	
There is no annual maximum benefit limit on outpatient prescription maintenance medications. **For employer groups with a District of Columbia or Virginia contract:** **Kaiser Permanente Mail Order Program:** You pay $3 for up to a 90-day* supply of generic drugs or brand name drugs. **For employer groups with a Maryland contract:** **Kaiser Permanente Mail Order Program, Medical Center, and Affiliated Network Pharmacies:** You pay $7.50 for up to a 90-day supply of generic drugs or brand name drugs. Authorization may be required for prescription drugs. **Certain drugs and biologicals may be dispensed for up to a 30-day supply only.*	You pay 100% for most prescription drugs.
8 – Ambulance services (Medically necessary ambulance services)	
You pay nothing for Medicare-covered ambulance services.	You pay 20% of Medicare-approved amounts or applicable fee schedule charge.(1)(2)

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
9 – Emergency care (You may go to any emergency room if you reasonably believe you need emergency care.)	
You pay $50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 48 hours for the same condition. Worldwide coverage.	You pay 20% of the facility charge or applicable copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.(1)(2) You pay 20% of doctor charges.(1)(2) NOT covered outside the U.S. except under limited circumstances.
10 – Urgently needed care (This is NOT emergency care, and in most cases, is out of the service area.)	
You pay $5 for each Medicare-covered urgently needed care visit. Worldwide coverage.	You pay 20% of Medicare-approved amounts or applicable copayment.(1)(2) NOT covered outside the U.S. except under limited circumstances.

(1) Each year, you pay a total of one $110 deductible.
(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.
(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the applicable inpatient hospital copayment or deductible for each benefit period. There is no limit to the number of benefit periods you can have.
(4) Lifetime reserve days can only be used once.
(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/ Utilization Review.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage" (KFHP-DCCOST-EOC (01/05); or KFHP-MDCOST-EOC (01/05); or KFHP-VACOST-EOC (01/05)). If you have any questions about this plan's benefits or costs, please contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Monday through Friday from 7:30 a.m. until 5:30 p.m. at (301) 468-6000 or 1-800-777-7902 outside the Washington, DC metro calling area. People who have difficulty with hearing or speaking may call our TTY number, 301-879-6380. The TTY number requires special telephone equipment.

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
11 – Ambulatory surgical services and outpatient hospital services	
You pay nothing for each Medicare-covered visit to an ambulatory surgical center.[5] You pay nothing for each Medicare-covered visit to an outpatient hospital facility.[5]	You pay 20% of Medicare-approved amounts for the doctor.[1][2] You pay 20% of outpatient facility charges.[1][2]
12 – Durable medical equipment (Includes wheelchairs, oxygen, etc.)	
You pay nothing for each Medicare-covered item.[5]	You pay 20% of Medicare-approved amounts.[1][2]
13 – Prosthetic devices (Includes braces, artificial limbs and eyes, etc.)	
You pay nothing for each Medicare-covered item.[5]	You pay 20% of Medicare-approved amounts.[1][2]
14 – Dental services	
You pay $30 for an office visit that includes the following services: • Oral exams up to 1 visit every six months • Cleanings up to 1 visit every six months • Fluoride treatment up to 1 visit every six months • Dental X-rays up to 1 visit every six months Additional benefits are available.[5]	In general, you pay 100% for dental services.

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
15 – Vision services	
You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. You pay all charges above the Medicare-approved amount for Medicare-covered eyewear.(5) Glaucoma screening for high-risk individuals, individuals with family history of glaucoma or individuals with diabetes is covered once per year. You pay $5 per visit.(5) You pay $5 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). You pay $5 for each routine eye exam. You pay 85% of the cost for contacts, limited to 1 pair of contact lenses every year. You pay 75% of the cost for lenses. You pay 75% of the cost for frames.	You are covered for one pair of eyeglasses or contact lenses after each cataract surgery.(1)(2) For people with Medicare who are at risk, you are covered for annual glaucoma screenings.(1)(2) You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye.(1)(2) You pay 100% for routine eye exams and glasses.

(1) Each year, you pay a total of one $110 deductible.
(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.
(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the applicable inpatient hospital copayment or deductible for each benefit period. There is no limit to the number of benefit periods you can have.
(4) Lifetime reserve days can only be used once.
(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/ Utilization Review.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage" (KFHP-DCCOST-EOC (01/05); or KFHP-MDCOST-EOC (01/05); or KFHP-VACOST-EOC (01/05)). If you have any questions about this plan's benefits or costs, please contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Monday through Friday from 7:30 a.m. until 5:30 p.m. at (301) 468-6000 or 1-800-777-7902 outside the Washington, DC metro calling area. People who have difficulty with hearing or speaking may call our TTY number, 301-879-6380. The TTY number requires special telephone equipment.

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
16 – Inpatient mental health care	
You pay nothing per benefit period[3] for a Medicare-covered stay in a network hospital.[5] There is a 190-day lifetime limit in a psychiatric hospital.	**If you have both Medicare Parts A&B:** You pay for each benefit period[3]: **Days 1-60:** an initial deductible of $876 (This is the 2004 amount and may change January 1, 2005.) **Days 61-90:** $219 each day (This is the 2004 amount and may change January 1, 2005.) **Days 91-150**: $438 each lifetime reserve day (This is the 2004 amount and may change January 1, 2005.)[4] Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.[4] **If you have Medicare Part B Only:** In general, you pay 100%.
17 – Skilled nursing facility (In a Medicare-certified skilled nursing facility)	
You pay nothing if Original Medicare would cover the stay.[5] You pay nothing for a medically necessary admission if Original Medicare would not cover the stay.[5]	**If you have both Medicare Parts A&B:** You pay for each benefit period[3], following at least a 3-day covered hospital stay: **Days 1-20:** $0 for each day **Days 21-100:** $109.50 for each day (This is the 2004 amount and may change January 1, 2005.)

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
17 – Skilled nursing facility (continued)	
Note: Original Medicare will only cover skilled nursing facility care following a related 3-day hospitalization. There is a limit of 100 days for each benefit period.(3)	There is a limit of 100 days for each benefit period.(3) **If you have Medicare Part B Only:** In general, you pay 100%.
18 – Home health agency care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	
There is no copayment for Medicare-covered home health visits.(5)	There is no copayment for all covered home health visits.
19 – Hospice	
If you have Medicare Parts A&B: You must receive care from a Medicare-certified hospice.(5) **If you have Medicare Part B Only:** You must receive care from a network hospice.(5)	**If you have both Medicare Parts A&B:** You pay part of the cost for outpatient drugs and inpatient respite care and you must receive care from a Medicare-certified hospice. **If you have Medicare Part B Only:** In general, you pay 100%.

(1) Each year, you pay a total of one $110 deductible.
(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.
(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the applicable inpatient hospital copayment or deductible for each benefit period. There is no limit to the number of benefit periods you can have.
(4) Lifetime reserve days can only be used once.
(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/ Utilization Review.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage" (KFHP-DCCOST-EOC (01/05); or KFHP-MDCOST-EOC (01/05); or KFHP-VACOST-EOC (01/05)). If you have any questions about this plan's benefits or costs, please contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Monday through Friday from 7:30 a.m. until 5:30 p.m. at (301) 468-6000 or 1-800-777-7902 outside the Washington, DC metro calling area. People who have difficulty with hearing or speaking may call our TTY number, 301-879-6380. The TTY number requires special telephone equipment.

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
20 – Chiropractic services	
You pay $5 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).[5]	You pay 20% of Medicare-approved amounts.[1][2] You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. You pay 100% for routine care.
21 – Podiatry services	
You pay $5 for each Medicare-covered visit (medically necessary foot care).[5]	You pay 20% of Medicare-approved amounts.[1][2] You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs. You pay 100% for routine care.
22 – Outpatient mental health care	
For Medicare-covered mental health services, you pay $5 for each individual/group therapy visit.[5]	You pay 50% of the Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges.[1][2]
23 – Outpatient substance abuse care	
For Medicare-covered services you pay $5 for each individual/group visit.[5]	You pay 20% of Medicare-approved amounts.[1][2]

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
24 – Outpatient rehabilitation services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	
You pay $5 for each Medicare-covered occupational therapy visit.(5) You pay $5 for each Medicare-covered physical therapy and/or speech/language therapy visit.(5)	You pay 20% of Medicare-approved amounts.(1)(2)
25 – Diabetes self-monitoring training and supplies (Includes coverage for glucose monitors, test strips, lancets, and Medicare-certified self-management training)	
You pay $5 for Medicare-covered diabetes self-monitoring training.(5) You pay nothing for each Medicare-covered diabetes supply item.	You pay 20% of Medicare-approved amounts.(1)(2)
26– Bone mass measurement (For people with Medicare who are at risk)	
You pay $5 for each Medicare-covered bone mass measurement.(5)	You pay 20% of Medicare-approved amounts.(1)(2)
27 – Colorectal screening exams (For people 50+ with Medicare)	
You pay $5 for each Medicare-covered colorectal screening exam.(5)	You pay 20% of Medicare-approved amounts.(1)(2)

(1) Each year, you pay a total of one $110 deductible.
(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.
(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the applicable inpatient hospital copayment or deductible for each benefit period. There is no limit to the number of benefit periods you can have.
(4) Lifetime reserve days can only be used once.
(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/ Utilization Review.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage" (KFHP-DCCOST-EOC (01/05); or KFHP-MDCOST-EOC (01/05); or KFHP-VACOST-EOC (01/05)). If you have any questions about this plan's benefits or costs, please contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Monday through Friday from 7:30 a.m. until 5:30 p.m. at (301) 468-6000 or 1-800-777-7902 outside the Washington, DC metro calling area. People who have difficulty with hearing or speaking may call our TTY number, 301-879-6380. The TTY number requires special telephone equipment.

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
28 – Immunizations (Flu vaccine, hepatitis B vaccine - for people with Medicare who are at risk, pneumonia vaccine)	
You pay nothing for the pneumonia and flu vaccines. Office visit copayment may apply. No referral necessary for pneumonia and flu vaccines. You pay $5 for the hepatitis B vaccine.(5)	There is no copayment for the pneumonia and flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine.(1)(2) You may only need the pneumonia vaccine once in your lifetime. Please contact your doctor for further details.
29 – Mammograms (annual screening) (For women 40+ with Medicare)	
You pay $5 for each Medicare-covered screening mammogram.(5) No referral necessary for Medicare-covered screenings.	You pay 20% of Medicare-approved amounts.(2) No referral necessary for Medicare-covered screenings.
30 – Pap smears and pelvic exams (For women with Medicare)	
You pay $5 for each Medicare-covered pap smear and pelvic exam.	There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk.(2) You pay 20% of Medicare-approved amounts for pelvic exams.(2)
31 – Prostate cancer screening exams (For men 50+ with Medicare)	
You pay $5 for each Medicare-covered prostate cancer screening exam.(5)	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services.(2)

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
32 – Hearing services	
In general, you pay 100% for routine hearing exams and hearing aids.(5) You pay $5 for each Medicare-covered hearing exam (diagnostic hearing exams).(5)	You pay 100% for routine hearing exams and hearing aids. You pay 20% of Medicare-approved amounts for diagnostic hearing exams.(1)(2)
33 – Routine physical exams	
You pay $5 for each exam.(5) You are covered up to one exam every year.	You pay 100% for routine physical exams.
34 – Health/wellness education	
You are covered for the following: • Health Ed classes • Newsletter • Nutritional training • Smoking cessation • Congestive heart program • Alternative medicine program • Nursing hotline • Disease management • Other wellness services Some services may require copayments.	You pay 100%.

(1) Each year, you pay a total of one $110 deductible.
(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.
(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the applicable inpatient hospital copayment or deductible for each benefit period. There is no limit to the number of benefit periods you can have.
(4) Lifetime reserve days can only be used once.
(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/ Utilization Review.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage" (KFHP-DCCOST-EOC (01/05); or KFHP-MDCOST-EOC (01/05); or KFHP-VACOST-EOC (01/05)). If you have any questions about this plan's benefits or costs, please contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Monday through Friday from 7:30 a.m. until 5:30 p.m. at (301) 468-6000 or 1-800-777-7902 outside the Washington, DC metro calling area. People who have difficulty with hearing or speaking may call our TTY number, 301-879-6380. The TTY number requires special telephone equipment.

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
35 – Outpatient kidney dialysis (within the Service Area)	
You pay nothing for Medicare-covered outpatient kidney dialysis at a Medicare-approved Dialysis Facility.[5]	You pay 20% of Medicare-approved amounts.[1][2]
36 – Self-administered injections (Certain medications, such as those for the treatment of anemia and anticoagulation therapies are covered for self-administration. Coverage of these medications requires approval from your physician and successful completion of self-administration teaching session(s)). For information on coverage for insulin, please see Outpatient Prescription Drugs – #6.	
There is no annual maximum benefit limit on self-administered injections. **Kaiser Permanente Mail Order Program:** You pay $3 for up to a 30-day supply of generic or brand name drugs **Kaiser Permanente Medical Center Pharmacy:** You pay $5 for up to a 30-day supply of generic or brand name drugs **Kaiser Permanente Affiliated Network Pharmacy:** You pay $10 for up to a 30-day supply of generic or brand name drugs	You pay 100%.

KAISER PERMANENTE MEDICARE PLUS	ORIGINAL MEDICARE
37 – Intravenous infusion medications (Medications prescribed in conjunction with home infusion therapy)	
There is no annual maximum benefit limit on intravenous infusion medications. You pay nothing.(5)	You pay 100%

(1) Each year, you pay a total of one $110 deductible.
(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.
(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the applicable inpatient hospital copayment or deductible for each benefit period. There is no limit to the number of benefit periods you can have.
(4) Lifetime reserve days can only be used once.
(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/ Utilization Review.

Medical care and services that are NOT covered (list of exclusions)

An "Exclusion" is an item or service that Kaiser Permanente Medicare Plus does not cover. You are responsible for paying for excluded items or services. Any service (except for an Emergency service or urgently needed service) that is not provided or arranged by a Plan Provider or not pre-authorized in advance may not be covered by Kaiser Permanente Medicare Plus. If you go to a provider outside of Kaiser Permanente Medicare Plus who accepts Medicare patients, your coverage would be the same as Original Medicare. Original Medicare deductibles and coinsurance apply and are your responsibility to pay.

In addition to any Exclusions or limitations described in the EOC, the following items and services are limited or not covered by Kaiser Permanente Medicare Plus.

- Abortions, unless the life of the mother is endangered as the result of carrying the fetus to full term, and in the case of incest or rape.
- Alternative care including but not limited to acupuncture; chiropractic; naturopathic; and therapeutic massage therapy services and supplies except as described in the EOC.
- Charges imposed by immediate relatives or members of your household.
- Cosmetic surgery, unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast reconstruction is covered when following a medically necessary mastectomy.
- Custodial Care, which includes care that helps members in the activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom; preparation of special diets; and supervision of medication that is usually self-administered.
- Domiciliary care. Care for you if you are capable of caring for yourself; however, you must be maintained in a monitored environment for health maintenance and safety.
- Elective or voluntary enhancement procedures, services and supplies including but not limited to: sex change operations, weight loss — except as described in the EOC — hair growth, sexual dysfunction, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.
- Emergency facility services for non-authorized, routine conditions not based on an Emergency Medical Condition.
- Employer or Government Responsibility
  a. Financial responsibility for services otherwise covered under this agreement for any illness, injury or condition to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employers' liability law. We will provide services even if it is unclear whether a member is entitled to a Financial Benefit. However, we may recover the value, calculated at non-member rates, of any such services provided under the EOC, from any source providing a Financial Benefit or from whom a Financial Benefit is due. In the alternative, we may recover such value from the member to the extent that a Financial Benefit is provided or payable only if the member does not receive claim under workers' compensation or employers' liability law because of the member's failure to diligently seek to establish his or her rights thereto or if a financial benefit is actually received by the member.
  b. Financial responsibility for services that an employer is required by law to provide.
  c. Services provided to veterans in Veteran's Affairs (VA) facilities. However, we will reimburse veterans for the cost-sharing for emergency services received at a VA hospital up to the amount that we charge for cost-sharing under Medicare Plus.
  d. Financial responsibility for services for any illness, injury or condition when the law requires such service to be provided only by or received from a government agency.

- If there is a reasonable doubt whether any benefit is available or is required to be provided under any workers' compensation or employers' liability law, and if the member diligently seeks to establish his or her rights to benefits, then services that otherwise would be provided under the EOC will be provided. Except that the value of such services at non-member rates is recoverable by us or our nominee from any source providing benefits or from whom benefits are due, or from the member, to the extent that the monetary benefits are provided, or payable or would have been required to be provided if the member had diligently sought to establish his or her rights to such benefits. This provision does not apply to Medicaid benefits.
- Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-qualifying clinical trial. Experimental procedures and items are those items and procedures determined by Kaiser Permanente and Original Medicare not to be generally accepted by the medical community. When deciding if a service or item is experimental, Kaiser Permanente will follow Medicare's manuals or will follow decisions already made by Medicare.
- Hearing aids and hearing examinations for prescribing, fitting or changing hearing aids.
- Homemaker services.
- Hospital and Skilled Nursing Facility services not covered include: a) charges for care and supplies not ordered by a Personal Physician or Plan Provider, if such care and supplies would not be paid for under Medicare guidelines; b) convenience and personal care items which are billed separately such as telephone, television or radio; c) private duty nurse; and, d) private room in a hospital, unless medically necessary.
- Independent medical examinations for the purpose of long-term disability.
- Intermediate care, which is care provided in an intermediate care facility.
- Hypnotism or hypnotic anesthesia services are not covered.
- Services to reverse voluntary, surgically induced infertility.
- Meals delivered to your home.
- Nursing care on a full-time basis in your home.
- Orthopedic shoes and supportive devices for the feet. Except therapeutic shoes for those suffering from diabetic foot disease and orthopedic shoes that are part of a leg brace and are included in the orthopedist's charge.
- Private duty nurses.
- Procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by Kaiser Permanente or covered by Medicare.
- Radial keratotomy and low vision aids and services.
- Routine foot care.
- Services that are not reasonable and necessary under Original Medicare guidelines.
- Services as a condition of probation, parole or any other third party court order unless a Plan Provider determines such services to be medically necessary and clinically appropriate.
- Surgical treatment of morbid obesity, except as described in the EOC.
- Treatment in a specialized alcoholism, drug abuse or drug addiction treatment facility or program, when in the judgment of a Plan Provider, the Member has not been or would not be responsive to therapeutic management or has not been or is not motivated.
- Veteran Benefits which were provided through the Veterans Administration.
- The following Vision Care Services:
  - Sunglasses without corrective lenses unless medically necessary
  - Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism
  - Eye exercises

- Cosmetic contact lenses
- All services related to contact lenses including examinations, fittings and dispensing, and follow up visits, except as described in the EOC.
- Any contact lenses you require after we provide an initial pair of lenses may be purchased at a Kaiser Permanente Optical Shop on a fee-for-service basis.
- Replacement of lost or broken lenses or frames

• The following Dental Care services:
- Services provided by or required to be provided by pedodontists or prosthodontists
- Except as specified in the EOC:
  - Hospitalization for any dental procedure
  - Setting of fractures or dislocations
  - Treatment of denture, bridgework and/or dental appliances due to loss or theft within 60 days
- Pharmacological regiments and implantations, including placement of dental implants, implant-supported abutments and prostheses
- Dental services related to procedures begun prior to your enrollment in Kaiser Permanente Medicare Plus
- Procedures relating to the change and maintenance of vertical dimension or the restoration of occlusion.
- Occlusal guards are excluded for any purpose other than control of habitual grinding.
- Placement of fixed bridgework solely for the purpose of achieving periodontal stability.

Prescription Drug Exclusions:

Kaiser Permanente Medicare Plus does not cover the following drugs and accessories:

• Non-Formulary drugs and accessories that are not deemed medically necessary.
• Any formulations or alternative delivery methods for medications not deemed medically necessary.
• Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes.
• Dental prescriptions other than those prescribed for pain relief or antibiotics.
• Replacement prescriptions necessitated by theft or loss
• Prescribed drugs and accessories for services that are excluded under Kaiser Permanente Medicare Plus.
• All drugs and accessories for the sole purpose of foreign travel.
• Growth hormones.
• Inhalation therapies for treatment or prevention of viral infections.
• Inhaled insulin
• Smoking cessation products.
• Drugs used for sexual dysfunction, sexual performance, athletic performance, anti-aging, mental performance, hair growth, non-prescription contraceptive supplies and devices, and non-prescription over-the-counter drugs.
• Special Packaging is not covered. Packaging of prescription medications is limited to Plan stated packaging.

.

Infertility Exclusions & Limitations:

(a) Cost of donor semen and donor eggs;
(b) Storage and freezing of eggs; and
(c) Services, other than artificial insemination, related to conception by artificial means, including but not limited to, in-vitro fertilization, ovum transplants, gamete intrafollopean transfer, zygote intrafallopean transfer and prescription drugs related to such services.
(d) Services to reverse involuntary, surgically induced infertility.

Limitation:
Covered benefits limited to a lifetime maximum of $100,000

Preventive and Comprehensive Dental Exclusions and Limitations

Dental services are limited as follows:

Exclusions

Neither Health Plan nor DBP provides coverage for the following:

1. Services of dentists or other practitioners of healing arts not associated with Health Plan and/or DBP except upon referral arranged by a Participating Dental Provider and authorized by us, or when required in a covered emergency. Such excluded services mean any kind of dental care and anything prescribed in connection therewith.
2. Hospitalization for any dental procedure, except as may be otherwise covered in your medical plan which is described in the EOC.
3. Any cosmetic, beautifying or elective procedure.
4. Services of Pedontists and/or Prosthodontists
5. Experimental procedures, implantations, or pharmacological regiments.
6. Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan that is described in the EOC.
7. Services for injuries or conditions which are covered under Workers' Compensation or Employer's Liability laws; services which are provided without cost to the Member by any municipality, county, or other political subdivision. This exclusion does not apply to any services that are covered by Medicaid.
8. Placement of dental implants, implant-supported abutments and prostheses.
9. Occlusal guards, except for the purpose of controlling habitual grinding.
10. The setting of fractures or dislocations, except as may be otherwise covered in your medical plan which is described in the EOC.
11. Treatment of malignancies, cysts or neoplasm or congenital malformations, except as may be otherwise covered in your medical plan which is described in the EOC.
12. Replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
13. Replacement of denture, bridgework and/or dental appliances previously supplied under the EOC, due to loss or theft, or for any reason within sixty (60) months of initial insertion.
14. Services which, in the opinion of the attending Participating Dental Provider, are not necessary for the Member's dental health.
15. Services pertaining, or related, to the Temporomandibular Joint (TMJ), except when those services are included on the dental fee schedule and are performed by the Member's Participating Dental Provider in that provider's office.
16. Charges for failure to keep a scheduled dental appointment.
17. Charges for second opinions, unless previously authorized by Health Plan.
18. Dental expenses incurred in connection with any dental procedure that was started prior to the Member's enrollment under the EOC. Examples include orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress.
19. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
20. Procedures relating to the change and maintenance of vertical dimension or the restoration of occlusion.
21. Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in the EOC.
22. Procedures not shown on the dental fee schedule listing are not covered under the EOC.

Limitations

Clinical situations that can effectively be treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure, in accordance with the "Standards of Care" established by DBP for its participating providers.

Additional limitations, such as how often we will cover a particular procedure, apply to some of the covered dental procedures listed in the dental fee schedule. Specific limits are set forth on the fee schedule, and are hereby incorporated by reference into the EOC.