Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street, Rockville, Maryland 20852

2012 Summary of Benefits
GOVERNMENT OF D.C.
HMO SIG – Mid-Large Groups ($10/$20)
(District of Columbia)

The following is a limited description of benefits offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). Not all services and procedures are covered by your benefits contract. This Summary of Benefits is for comparison purposes only and does not create rights not given through the benefit plan.

IMPORTANT NOTICE - Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. believes that your Plan is "a grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when PPACA was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the PPACA that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the PPACA.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause your Plan to change from grandfathered health plan status can be directed to your plan administrator. If your Plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov./ebsa/healthreform. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

PLAN DETAILS		
Copayments	$10 (PCP) / $20 (Specialty)	
Coinsurance (Plan pays / Member pays)	100% / 0% except as otherwise indicated	
Deductible	None	
Maximum Annual Copayment	Individual: $3,500	Family: $9,400

BENEFITS	MEMBER PAYS
OUTPATIENT SERVICES	
Preventive Health Office Visit	No charge
Preventive Health Screening Tests	No charge
Office Visit for Illness	
Primary Care Office Visit	$10 per visit (Copayment waived for children under age 5)
Specialty Care Office Visit	$20 per visit
Routine pre-natal visit (after confirmation of pregnancy) and first post-natal visit	No charge
Diagnostic Tests and Procedures, X-rays & Laboratory Services	No charge
Specialty Imaging (e.g., CT, MRI, PET scan & Nuclear Medicine)	$50 per test
Outpatient Surgery (other than in a provider's office)	$50 per procedure
HOSPITAL SERVICES	
Inpatient hospital care, including inpatient maternity care	$100 per admission
Inpatient physician services	No charge
CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES	
Inpatient hospital care	$100 per admission
Outpatient services	$10 per visit for individual therapy; $5 per visit for group therapy
THERAPY & REHABILITATION SERVICES	
Inpatient hospital care	$100 per admission
Outpatient services (Up to 90 consecutive days of treatment per injury, incident or condition)	$20 per visit
INFERTILITY SERVICES	
Office visits	50% of allowable charge
All other covered services for treatment of infertility (In vitro fertilization benefit limited to 3 attempts per lifetime and a lifetime maximum Health Plan benefit of $100,000)	50% of allowable charge
URGENT CARE & EMERGENCY SERVICES	
Urgent Care Office Visit	$10 per visit (PCP) / $20 per visit (Specialty)
After hours Urgent Care or Urgent Care Center	$20 per visit
Hospital Emergency Room (waived if admitted as inpatient)	$50 per visit
Ambulance	No charge

BENEFITS	MEMBER PAYS
HOSPITAL ALTERNATIVES	
Skilled Nursing Facility (limited to 100 days per contract year)	$100 per admission
Home Health Care	No charge
Hospice Care	No charge
OTHER SERVICES	
Durable Medical Equipment (DME)	
Basic DME	50% of allowable charge
Oxygen equipment	50% of allowable charge
Prosthetics	
Internal prosthetics	No charge
External prosthetics	50% of allowable charge
Vision	
Office visit for medical conditions of the eye	$10 per visit (PCP) / $20 per visit (Specialty)
Routine eye refractions to determine need for vision correction	$10 per visit with Optometrist $20 per visit with Ophthalmologist (referral required)
Eyeglass frames and lenses (limited to one pair of glasses per contract year)	Member receives 25% discount off retail price when purchased from Plan Providers
Contact lenses	Member receives 15% discount off retail price on initial pair of contact lenses only, when purchased from Plan Providers
Prescription Drugs	
Covered prescription drugs (up to a 30-day supply) (Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies) (Up to a 90-day supply for 2 copays through Mail Order)	**Plan Pharmacy –** $10 Generic / $20 Preferred Brand / $35 Non-Preferred Brand **Participating Network Pharmacy –** $20 Generic / $40 Preferred Brand / $55 Non-Preferred Brand **Mail Order –** $8 Generic / $18 Preferred Brand / $33 Non-Preferred Brand

RIDERED BENEFITS	MEMBER PAYS
Complementary Alternative Medicine	
Chiropractic Services (Limited to 20 visits per contract year)	$20 per visit
Acupuncture Services (Limited to 20 visits per contract year)	$20 per visit
Dental	
Covered dental services	Plan C - $30 for preventive dental care services

This Benefit and Service Summary does not fully describe the exclusions and limitations associated with your Kaiser Permanente coverage. For a full list of the general and benefit specific exclusions under your coverage, please refer to your KFHP-MAS Evidence of Coverage (EOC). Your EOC provides you with information on what services and supplies will not be covered, regardless of whether the service is medically necessary.

NOTE: This Summary of Benefits is for comparison purposes only and does not create rights not given through the benefit plan.

Form Numbers: DC-GRP-SEC1(01/12); DC-GRP-SEC2(01/12); DC-GRP-SEC3(01/12); DCLG-ALL-SEC4(01/10); DC-GRP-SEC5(07/11); DC-GRP-SEC6(01/11); DC-GRP-SEC7(01/12); DC-GRP-APPX-DEF(01/12); DC-GRP-HMO-COST(01/12); and any amendments or riders attached thereto.