



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

**2010 Summary of Benefits
ACS STATE & LOCAL SOLUTIONS, INC.
DEDUCTIBLE HMO SEL Plan 4
Mid-Large Groups (\$15/\$25 – 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.

PLAN DETAILS	
Copayments	\$15 (PCP) / \$25 (Specialty)
Coinsurance (Plan pays / Member pays)	80%/20% except as otherwise indicated
Deductible	Individual: \$500 Family: \$1,000
Maximum Annual Copayment	Individual: \$2,000 Family: \$4,000
Lifetime Maximum	No lifetime maximum
BENEFITS	MEMBER PAYS
OUTPATIENT SERVICES	
Preventive Health Office Visit	No charge
Preventive Health Screening Test	No charge
Office Visits for Illness	
Primary Care	\$15 per visit (Copayment waived for children under age 5)
Specialty Care	\$25 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	20% of allowable charge after Deductible met
Specialty Imaging (e.g., CT, MRI, PET scan & Nuclear Medicine)	20% of allowable charge after Deductible met
Outpatient Surgery (other than in a provider's office)	20% of allowable charge after Deductible met
HOSPITAL SERVICES	
Inpatient hospital care, including inpatient maternity care	20% of allowable charge after Deductible met
Inpatient physician services	20% of allowable charge after Deductible met
CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES	
Inpatient hospital care	20% of allowable charge after Deductible met
Outpatient services	\$20 per visit for individual therapy; \$10 per visit for group therapy
THERAPY & REHABILITATION SERVICES	
Inpatient hospital care	20% of allowable charge after Deductible met
Outpatient services	\$25 per visit
INFERTILITY SERVICES	
Office visits	50% of allowable charge
All other covered services for treatment of infertility	50% of allowable charge
URGENT CARE & EMERGENCY SERVICES	
Urgent Care Office Visit	\$15 per visit (PCP) / \$25 per visit (Specialty)
After hours Urgent Care or Urgent Care Center	\$25 per visit
Hospital Emergency Room	\$75 per visit
Ambulance	\$100 per encounter
HOSPITAL ALTERNATIVES	
Skilled Nursing Facility (limited to 100 days per contract year)	20% of allowable charge after Deductible met
Home Health Care	20% of allowable charge after Deductible met
Hospice Care	20% of allowable charge after Deductible met
OTHER SERVICES	
Durable Medical Equipment (DME)	
Inpatient Services	
Basic DME	20% of allowable charge after Deductible met
Oxygen equipment	20% of allowable charge after Deductible met
Outpatient Services	
Basic DME	50% of allowable charge
Oxygen equipment	50% of allowable charge

BENEFITS	MEMBER PAYS
Prosthetics	
Internal prosthetics	20% of allowable charge after Deductible met
External prosthetics	P&O limited to breast prostheses, mastectomy bras, urologic & ostomy supplies
Vision	
Office visit for medical conditions of the eye	\$15 per visit (PCP) / \$25 per visit (Specialty)
Routine eye refractions to determine need for vision correction	\$15 per visit with Optometrist \$25 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)	Plan Pharmacy – \$15 Generic / \$25 Preferred Brand / \$40 Non-Preferred Brand Participating Network Pharmacy – \$25 Generic / \$45 Preferred Brand / \$60 Non-Preferred Brand
(Up to a 90-day supply for 2 copays through Mail Order)	Mail Order – \$13 Generic / \$23 Preferred Brand / \$38 Non-Preferred Brand

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 and limitations 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.

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Form Numbers: DCLG-ALL-SEC1(4/09); DCLG-ALL-SEC2(01/09); DCLG-ALL-SEC3(1/09); DCLG-ALL-SEC4(4/09); DCLG-ALL-SEC5(1/06); DCLG-ALL-SEC6(1/09); DCLG-ALL-SEC7(1/09); DCLG-ALL-APPX-DEF(1/09); DC-HMO-COST(1/09); and any amendments or riders attached thereto.