

**Flexible Choice – Small Group
Plan 1 (100/90/70 – \$10-\$20/\$30)
(Virginia)**

 Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street, Rockville, Maryland 20849

 Kaiser Permanente Insurance Company
One Kaiser Plaza, Oakland, California 94612

The following is a limited description of the Flexible Choice coverage provided through Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS) and Kaiser Permanente Insurance Company (KPIC). This is only a summary and does not fully describe your benefit coverage. For details on your HMO benefit coverage, please refer to your Group Evidence of Coverage and applicable Riders. For details on your Participating Provider (PHCS) coverage and your Out-of-Network coverage, please refer to your Certificate of Insurance and Schedule of Coverage. The Evidence of Coverage is the legally binding document between KFHP-MAS and its members. The Certificate of Insurance is the legally binding document between KPIC and its members. In the event of ambiguity, or a conflict between this summary and the Evidence of Coverage and/or Certificate of Insurance, the Evidence of Coverage and/or Certificate of Insurance shall control.

DEDUCTIBLE APPLIES TO OPTIONS 2 AND 3, EXCEPT WHERE OTHERWISE INDICATED

| PLAN DETAILS | Option 1 KFHP-MAS Providers | Option 2, PHCS Participating Providers | Option 3 Out-of-Network Providers |
|--|--|---|---|
| Copayments | \$10 | \$20/\$30 | N/A |
| Coinsurance (Plan pays / Member pays) | 100% / 0% except as otherwise indicated | 90% / 10% MAC* except as otherwise indicated | 70% / 30% MAC* except as otherwise indicated |
| Deductible (per contract year) | None | Individual: \$200 Family: \$400 | Individual: \$400 Family: \$800 |
| Out-of-Pocket Maximum (per contract year) | Individual: \$1,000 Family: \$2,000 | Individual: \$2,000 Family: \$4,000 | Individual: \$4,000 Family: \$8,000 |
| Lifetime Maximum | Unlimited | \$1 Million | |
| BENEFITS | MEMBER PAYS | | |
| | Option 1 KFHP-MAS Providers | Option 2, PHCS Participating Providers | Option 3 Out-of-Network Providers |
| OUTPATIENT SERVICES | | | |
| Preventive Health Office Visit | \$10 per visit (Copayment waived for children under age 5) | \$20/\$30 per visit (Deductible waived) | 30% of MAC* after Deductible met |
| Preventive Health Screening Test | No charge | 10% of MAC* after Deductible met | 30% of MAC* after Deductible met |
| Office Visit for Illness | | | |
| Primary Care | \$10 per visit (Copayment waived for children under age 5) | \$20 per visit (Deductible waived) | 30% of MAC* after Deductible met |
| Specialist Care | \$10 per visit | \$30 per visit (Deductible waived) | 30% of MAC* after Deductible met |
| Diagnostic Tests and Procedures, X-rays & Laboratory Services | No charge | 10% of MAC* after Deductible met | 30% of MAC* after Deductible met |
| Routine pre-natal visit (after confirmation of pregnancy) and first post-natal visit | No charge | \$20 per visit (Deductible waived) | 30% of MAC* after Deductible met |
| Outpatient Surgery | \$25 per procedure | 10% of MAC* after Deductible met | 30% of MAC* after Deductible met |
| HOSPITAL SERVICES | | | |
| Inpatient hospital care, including inpatient maternity care | No charge | 10% of MAC* after Deductible met | 30% of MAC* after Deductible met |
| Inpatient physician services | No charge | 10% of MAC* after Deductible met | 30% of MAC* after Deductible met |
| CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES | | | |
| Inpatient hospital care | No charge | 10% of MAC* after Deductible met (See COI & SOC for benefit limits) | 30% of MAC* after Deductible met (See COI & SOC for benefit limits) |
| Outpatient services | \$10 per visit | \$30 per visit (Deductible waived) | 30% of MAC* after Deductible met |

* MAC = Maximum Allowable Charge

Deductible applies to Options 2 and 3, except where otherwise indicated

| BENEFITS | MEMBER PAYS | | |
|---|--|--|--|
| | Option 1 KFHP-MAS Providers | Option 2, PHCS Participating Providers | Option 3 Out-of-Network Providers |
| THERAPY & REHABILITATION SERVICES | | | |
| Inpatient hospital care | No charge (Up to 90 consecutive days of treatment per injury, incident or condition) | 10% of MAC* after Deductible met (Limited to 60 days per contract year for Options 2 & 3) | 30% of MAC* after Deductible met (Limited to 60 days per contract year for Options 2 & 3) |
| Outpatient services | \$10 per visit (Up to 90 consecutive days of treatment per injury, incident or condition) | \$30 per visit (Deductible waived) (Limited to 90 days per contract year for Options 2 & 3) | 30% of MAC* after Deductible met (Limited to 90 days per contract year for Options 2 & 3) |
| INFERTILITY SERVICES | | | |
| Office visits | 50% of AC† | \$30 per visit (Deductible waived) | 30% of MAC* after Deductible met |
| All other covered services for treatment of infertility | 50% of AC† | 50% of MAC* after Deductible met (See COI for benefit limits) | 50% of MAC* after Deductible met (See COI for benefit limits) |
| URGENT CARE & EMERGENCY SERVICES | | | |
| After hours Urgent Care or Urgent Care Center | Office Visit: \$25 per visit Other Services: No charge | Office Visit: \$25 per visit (Deductible waived) Other Services: 10% of MAC* after Deductible met | Office Visit: No charge after \$25 Deductible Other Services: 30% of MAC* after Deductible met |
| Hospital Emergency Room | \$75 [‡] per visit | Covered in Option 1 | Covered in Option 1 |
| Ambulance | \$100 per encounter | Covered in Option 1 | Covered in Option 1 |
| HOSPITAL ALTERNATIVES | | | |
| Skilled Nursing Facility | No charge (Limited to 60 days per contract year) | 10% of MAC* after Deductible met (Limited to combined maximum of 40 days per contract year in Options 2 & 3) | 30% of MAC* after Deductible met (Limited to combined maximum of 40 days per contract year in Options 2 & 3) |
| Home Health Care | No charge | 10% of MAC* after Deductible met (Limited to combined maximum of 60 days per contract year in Options 2 & 3) | 30% of MAC* after Deductible met (Limited to combined maximum of 60 days per contract year in Options 2 & 3) |
| Hospice Care | No charge | 10% of MAC* after Deductible met (Benefit maximums apply) | 30% of MAC* after Deductible met (Benefit maximums apply) |
| OTHER SERVICES | | | |
| Durable Medical Equipment (DME) | | | |
| Basic DME | 20% of AC† (Covered for up to 3 months following an Inpatient Stay) | 30% of MAC* after Deductible met (Limited to an annual maximum for all covered DME and prosthetics of \$3,000 combined for Options 2 & 3) | 40% of MAC* after Deductible met (Limited to an annual maximum for all covered DME and prosthetics of \$3,000 combined for Options 2 & 3) |
| Prosthetics | | | |
| Internal prosthetics | 20% of AC† | 30% of MAC* after Deductible met (Limited to an annual maximum for all covered DME and prosthetics of \$3,000 combined for Options 2 & 3) | 40% of MAC* after Deductible met (Limited to an annual maximum for all covered DME and prosthetics of \$3,000 combined for Options 2 & 3) |
| External prosthetics | Not covered except for breast prostheses and mastectomy bras | Not covered except for breast prostheses and mastectomy bras | Not covered except for breast prostheses and mastectomy bras |
| Vision | | | |
| Office visit for medical conditions of the eye | \$10 per visit | \$20 / \$30 per visit (Deductible waived) | 30% of MAC* after Deductible met |

† AC = Allowable Charge

* MAC = Maximum Allowable Charge

‡ Emergency Room Copayment waived if admitted.

Deductible applies to Options 2 and 3, except where otherwise indicated

| BENEFITS | MEMBER PAYS | | |
|---|---|--|--|
| | Option 1 KFHP-MAS Providers | Option 2, PHCS Participating Providers | Option 3 Out-of-Network Providers |
| Routine eye refractions to determine need for vision correction | \$10 per visit | Optometrist: \$20 per visit (Deductible waived) Ophthalmologist: \$30 per visit (Deductible waived) | 30% of MAC* after Deductible met |
| Eyeglass lenses | \$150 allowance, 1 per 12 months | Not Available | 30% of MAC* after Deductible met 1 per 24 months (Limited to \$150 allowance) |
| An eyeglass frame | \$100 allowance, 1 per 12 months | Not Available | 30% of MAC* after Deductible met 1 per 24 months (Limited to \$100 allowance) |
| Contact lenses | 15% Discount, no Max. for 1 st pair only | Not Available | 30% of MAC* after Deductible met 1 per 24 months (Limited to \$50 allowance) |
| PRESCRIPTION DRUGS | HMO MEDICAL CENTER PHARMACIES | PARTICIPATING COMMUNITY PHARMACIES | NON-PARTICIPATING PHARMACIES |
| (up to a 30-day supply) Generic: Brand Preferred*: Brand Non-Preferred*: | \$10 Copay \$20 Copay \$35 Copay | \$20 Copay (Deductible waived) \$35 Copay (Deductible waived) \$50 Copay (Deductible waived) | \$20 Copay (Deductible waived) \$35 Copay (Deductible waived) \$50 Copay (Deductible waived) (\$5,000 annual benefit maximum) |

* MAC = Maximum Allowable Charge

This Benefit and Service Summary does not fully describe the exclusions and limitations associated with your Flexible Choice coverage. For a full list of the general and benefit specific exclusions and limitations under your Flexible Choice coverage, please refer to your KFHP-MAS Evidence of Coverage (EOC) and/or KPIC Certificate of Insurance (COI). Your EOC and/or COI provides you with information on what services and supplies will not be covered, regardless of whether the service is medically necessary. Pre-certification is required for all Option 2 and 3 inpatient services and certain outpatient services.

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

Form Numbers: KFHP-MAS: VALG-ALL-SEC1(1/06); VALG-ALL-SEC2(1/06); VALG-ALL-SEC3 (1/06); VALG-ALL-SEC4 (1/06); VALG-ALL-SEC5(05/04); VALG-ALL-SEC6(1/04); VALG-ALL-SEC7(1/06); VALG-ALL-APPX-DEF (1/06); VALG-HMO-COST(1/06) and any amendments or riders attached thereto.

KPIC: GC-FP-VA; GC-TOC-VA; GC-INTRO-VA; GC-GDEF-VA; GC-ELIG-VA; GC-PRECERT-VA; GC-DED-VA; GC-GBEN-VA; GC-POS-OPBEN-VA; GC-COC-FED-VA; GC-COC-VA; GC-COB-VA; GC-CLAIMS-VA; GC-GPROV-VA; GC-ERISA; D-105-VA; GC-SCH-POS-VA; GP-POS-VA and any amendments or riders attached thereto.