2010 Summary of Benefits
GEORGETOWN UNIVERSITY
POS SEL – Mid-Large Groups
($5; 80%/20%)
(District of Columbia)

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

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	IN-PLAN	OUT-OF-PLAN
Copayments	$5 (PCP) / $5 (Specialty)	Not applicable
Coinsurance (Plan pays / Member pays)	100% / 0% except as otherwise indicated	80% / 20% except as otherwise indicated
Deductible (per contract year)	None	Individual: $300 Family: $600
Out-of-Pocket Maximum (per contract year)	Not applicable	Individual: $3,000 Family: $6,000
Lifetime Maximum	No lifetime maximum	$1,000,000

BENEFITS	MEMBER PAYS IN-PLAN	MEMBER PAYS OUT-OF-PLAN
OUTPATIENT SERVICES		
Preventive Health Office Visits	No charge	20% of UCR*
Preventive Health Screening Tests	No charge	20% of UCR*
Office Visits for Illness		
Primary Care	$5 per visit (Copayment waived for children under age 5)	20% of UCR*
Specialty Care	$5 per visit	20% of UCR*
Routine pre-natal visits (after confirmation of pregnancy) and first post-natal visit	No charge	20% of UCR*
Diagnostic Tests and Procedures, X-rays & Laboratory Services	No charge	20% of UCR*
Specialty Imaging (e.g., CT, MRI, PET scan & Nuclear Medicine)	No charge	20% of UCR*
Outpatient Surgery (other than in a provider's office)	$5 per procedure	20% of UCR*
HOSPITAL SERVICES		
Inpatient hospital care, including inpatient maternity care	No charge	20% of UCR*
Inpatient physician services	No charge	20% of UCR*
CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES		
Inpatient hospital care	No charge	20% of UCR*
Outpatient services	Individual therapy: $20 per visit Group therapy: $10 per visit	20% of UCR*
THERAPY & REHABILITATION SERVICES		
Inpatient hospital care	No charge	20% of UCR*
Outpatient services	$5 per visit	20% of UCR*
INFERTILITY SERVICES		
Office visits	50% of AC†	60% of UCR*
All other covered services for treatment of infertility	50% of AC†	60% of UCR*
URGENT CARE & EMERGENCY SERVICES		
Urgent Care Office Visit	$5 per visit (PCP) / $5 per visit (Specialty)	20% of UCR*
After hours Urgent Care or Urgent Care Center	$5 per visit	20% of UCR*
Hospital Emergency Room (waived if admitted as inpatient)	$50 per visit	Same as In-Plan
Ambulance	No charge	20% of UCR*

* UCR = Usual, customary and reasonable charge. The general charge made by providers within a geographic area for illness or injury of comparable nature and severity.
† AC = Allowable Charge

BENEFITS	MEMBER PAYS IN-PLAN	MEMBER PAYS OUT-OF-PLAN
HOSPITAL ALTERNATIVES		
Skilled Nursing Facility (limited to 100 days per contract year)	No charge	20% of UCR*
Home Health Care	No charge	20% of UCR*
Hospice Care	No charge	20% of UCR*
OTHER SERVICES		
Durable Medical Equipment (DME)		
Basic DME	No charge	20% of UCR*
Oxygen equipment	No charge for 1st 3 months then 50% of AC† thereafter	20% of UCR* for 1st 3 months then 60% of UCR* thereafter
Prosthetics		
Internal prosthetics	No charge	20% of UCR*
External prosthetics	No charge	20% of UCR*
Vision		
Office visit for medical conditions of the eye	$5 per visit (PCP) / $5 per visit (Specialty)	20% of UCR*
Routine eye refractions to determine need for vision correction	$5 per visit with Optometrist $5 per visit with Ophthalmologist (referral required)	20% of UCR*
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	Member receives 10% 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	Member receives 5% discount off retail price on initial pair of contact lenses only, when purchased from Plan Providers
Prescription Drugs		
Covered prescription drugs (up to a 60-day supply) (Up to a 90-day supply for 1.5 copays)	**Plan Pharmacy –** $5 **Participating Network Pharmacy –** $15 **Mail Order –** $3	See In-Plan benefits

RIDERED BENEFITS	MEMBER PAYS IN-PLAN	MEMBER PAYS OUT-OF-PLAN
Complementary Alternative Medicine		
Chiropractic Services (Limited to 20 visits per contract year)	$15 per visit	20% of UCR*
Acupuncture Services (Limited to 20 visits per contract year)	$15 per visit	20% of UCR*

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† AC = Allowable Charge

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.

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Form Numbers: DCLG-ALL-SEC1(4/09); DCLG-ALL-SEC2(01/09); DCLG-ALL-SEC3(11/09); 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-POS-COST(11/09); and any amendments or riders attached thereto.