



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

**Summary of Benefits  
ALEXANDRIA SANITATION  
AUTHORITY**

**Flexible Choice – Mid-Large Groups  
Plan 21 (100/100/70 – \$10/\$20-\$20/\$30)  
(Virginia)**

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 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 legal 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 Participating Providers	Option 3 Out-of-Network Providers
Copayments	\$10/\$20	\$20/\$30	N/A
Coinsurance (Plan pays / Member pays)	100% / 0% except as otherwise indicated	100% / 0% 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 Participating Providers	Option 3 Out-of-Network Providers
<b>OUTPATIENT SERVICES</b>			
Preventive Health Office Visit	No charge	\$20/\$30 per visit (Deductible waived)	30% of MAC* after Deductible met
<b>Office Visit for Illness</b>			
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	\$20 per visit	\$30 per visit (Deductible waived)	30% of MAC* after Deductible met
Diagnostic Tests and Procedures, X-rays & Laboratory Services	No charge	No charge after Deductible met	30% of MAC* after Deductible met
Specialty Imaging	\$50 per test	No charge 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	No charge	No charge after Deductible met	30% of MAC* after Deductible met
<b>HOSPITAL SERVICES</b>			
Inpatient hospital care, including inpatient maternity care	No charge	No charge after Deductible met	30% of MAC* after Deductible met
Inpatient physician services	No charge	No charge after Deductible met	30% of MAC* after Deductible met
<b>CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES</b>			
Inpatient hospital care	No charge	No charge after Deductible met (See COI & SOC for benefit limits)	30% of MAC* after Deductible met (See COI & SOC for benefit limits)
Outpatient services	\$20 per visit	\$30 per visit (Deductible waived) (See COI & SOC for benefit limits)	30% of MAC* after Deductible met (See COI & SOC for benefit limits)

\* 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 Participating Providers	Option 3 Out-of-Network Providers
<b>THERAPY &amp; REHABILITATION SERVICES</b>			
Inpatient hospital care	No charge (Up to 90 consecutive days of treatment per injury, incident or condition)	No charge after Deductible met (Limited to 60 days per condition per contract year for Options 2 & 3)	30% of MAC* after Deductible met (Limited to 60 days per condition per contract year for Options 2 & 3)
Outpatient services	\$20 per visit (Up to 90 consecutive days of treatment per injury, incident or condition)	\$30 per visit (Deductible waived) (Limited to 90 visits per condition per contract year for Options 2 & 3)	30% of MAC* after Deductible met (Limited to 90 visits per condition per contract year for Options 2 & 3)
<b>INFERTILITY SERVICES</b>			
Office visits	50% of AC <sup>†</sup>	50% of MAC* after Deductible met (See COI for benefit limits)	50% of MAC* after Deductible met (See COI for benefit limits)
All other covered services for treatment of infertility	50% of AC <sup>†</sup>	50% of MAC* after Deductible met (See COI for benefit limits)	50% of MAC* after Deductible met (See COI for benefit limits)
<b>URGENT CARE &amp; EMERGENCY SERVICES</b>			
After hours Urgent Care or Urgent Care Center	\$20 Copay  Other Services: No charge	Office Visit: \$30 per visit (Deductible waived)  Other Services: No charge after Deductible met	Office Visit: 30% of MAC* (Deductible waived)  Other Services: 30% of MAC* after Deductible met
Hospital Emergency Room	\$75 per visit <sup>‡</sup>	Covered in Option 1 Only	
Ambulance	\$100 per encounter	Covered in Option 1 Only	
<b>HOSPITAL ALTERNATIVES</b>			
Skilled Nursing Facility	No charge (Limited to 60 days per contract year)	No charge 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	No charge after Deductible met (Limited to combined maximum of 60 visits per contract year in Options 2 & 3)	30% of MAC* after Deductible met (Limited to combined maximum of 60 visits per contract year in Options 2 & 3)
Hospice Care	No charge	No charge after Deductible met (Inpatient care limited to a combined benefit maximum of 30 days per policy year in Options 2 & 3. See COI & SOC for benefit limits)	30% of MAC* after Deductible met (Inpatient care limited to a combined benefit maximum of 30 days per policy year in Options 2 & 3. See COI & SOC for benefit limits)
<b>OTHER SERVICES</b>			
Durable Medical Equipment (DME)			
Basic DME	No charge	50% of MAC* after Deductible met (Limited to an annual maximum for all covered DME, prosthetics and orthotics of \$5,000 combined for Options 2 & 3)	50% of MAC* after Deductible met (Limited to an annual maximum for all covered DME, prosthetics and orthotics of \$5,000 combined for Options 2 & 3)
Prosthetics			
Internal prosthetics	No charge	50% of MAC* after Deductible met (Limited to an annual maximum for all covered DME, prosthetics and orthotics of \$5,000 combined for Options 2 & 3)	50% of MAC* after Deductible met (Limited to an annual maximum for all covered DME, prosthetics and orthotics of \$5,000 combined for Options 2 & 3)
External prosthetics	No charge	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 (PCP) / \$20 (Specialist) per visit	\$20 / \$30 per visit (Deductible waived)	30% of MAC* after Deductible met

\* MAC = Maximum Allowable Charge

<sup>†</sup> AC = Allowable Charge

<sup>‡</sup> 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 Participating Providers	Option 3 Out-of-Network Providers
Routine eye refractions to determine need for vision correction	Optometrist: \$10 per visit  Ophthalmologist: \$20 per visit (Referral required)	Optometrist: \$20 per visit (Deductible waived)  Ophthalmologist: \$30 per visit (Deductible waived)	30% of MAC* after Deductible met
Eyeglass lenses	25% discount off retail price when purchased from Plan Providers 1 per 12 months	Not Available	30% of MAC* after Deductible met 1 per 24 months (Limited to \$150 allowance)
An eyeglass frame	25% discount off retail price when purchased from Plan Providers 1 per 12 months	Not Available	30% of MAC* after Deductible met 1 per 24 months (Limited to \$100 allowance)
Contact lenses	15% discount off retail price on initial fitting for 1 <sup>st</sup> pair only, when purchased from Plan Providers	Not Available	30% of MAC* after Deductible met 1 per 24 months (Limited to \$50 allowance)

RIDERED BENEFITS	MEMBER PAYS		
	Option 1 KFHP-MAS Providers	Option 2 Participating Providers	Option 3 Out-of-Network Providers
Chiropractic Services			
Limited to manual manipulation of the spine to correct subluxation	\$20 per visit (Limited to 20 visits per Contract Year)	Office Visit: \$30 per visit (Deductible waived)  Other Services: No charge after Deductible met  (Limited to a Combined Benefit Maximum of 20 visits per Policy Year for Options 2 & 3)	30% of MAC* after Deductible met  (Limited to a Combined Benefit Maximum of 20 visits per Policy Year for Options 2 & 3)
Hearing Aids			
Hearing Tests for Hearing Aids	\$20 per visit	Available in Option 1 Only	
Hearing Aids	No charge up to Health Plan maximum payment (Limited to benefit maximum of \$1,000 per hearing aid for each hearing-impaired ear every 36 months.)	Available in Option 1 Only	

\* 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:** VALG-ALL-SEC1(1/08); VALG-ALL-SEC2(1/08); VALG-ALL-SEC3 (1/08); VALG-ALL-SEC4 (1/08); VALG-ALL-SEC5(05/04); VALG-ALL-SEC6(1/04); VALG-ALL-SEC7(1/06); VALG-ALL-APPX-DEF (1/06); VALG-HMO-COST(1/08); 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 (rev 02/06); GP-POS-VA and any amendments or riders attached thereto.