KAISER PERMANENTE

Kaiser Foundation Health Plan of Colorado

http://www.kaiserpermanente.org

2001

A Health Maintenance Organization

Serving: *Metropolitan Denver, Colorado area*
Colorado Springs, Colorado area

Enrollment in this Plan is limited; see page 59 for requirements.

This Plan has commendable accreditation from the NCQA. See the 2001 Guide for more information on NCQA.

Enrollment codes for this Plan:

651 Self Only
652 Self and Family

Authorized for distribution by the:

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OPM — United States Office of Personnel Management — Retirement and Insurance Service — http://www.opm.gov/insure

FEHB — Federal Employees Health Benefits Program

RI 73-019

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Introduction

Kaiser Foundation Health Plan of Colorado
2500 South Havana Street
Aurora, Colorado 80014

This brochure describes the benefits of Kaiser Foundation Health Plan of Colorado under our contract (CS 1268) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Kaiser Foundation Health Plan of Colorado.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with the Colorado Permanente Medical Group (Plan physicians) in the Denver/Boulder area to provide care in our Plan Medical Offices and network physicians (Plan physicians) in the Colorado Springs area. These Plan physicians are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee-for-service and incentive payments, for services they provide and services that are referred. If you would like further information about the way we pay Plan physicians to provide or arrange medical and hospital care in your service area, please call the Customer Service Center at 303/338-3800, or for Colorado Springs members, 888/681-7878.

Patients' Bill of Rights

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

We are a federally qualified health maintenance organization, and we have provided health care services to the Denver, Colorado area since 1969. Kaiser Foundation Health Plan of Colorado is a Colorado not-for-profit organization. This Plan is part of the Kaiser Permanente Medical Care Program, a group of not-for-profit organizations and contracting medical groups that serve over 8 million members nationwide. Our Medical Group, the Colorado Permanente Medical Group, P.C., operates Plan medical offices in the Denver/Boulder area. For the Colorado Springs area, we offer you services through participating providers.

If you want more information about us, call our Customer Service Center at 303/338-3800 for Denver members or 888/681-7878 for Colorado Springs members, or write to Kaiser Foundation Health Plan of Colorado, Customer Service Center, 2500 South Havana Street, Aurora, Colorado 80014-1622. You may also visit our website at www.kaiserpermanente.org.

Service Area

To enroll in this Plan, you must live in our service area. This is where our providers practice. Our service area is:

Denver. These zip codes in Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld counties: 80001-7, 80010-22, 80024-28, 80030-31, 80033-34, 80036-38, 80040-42, 80044-47, 80102, 80104, 80107, 80110-12, 80116-17, 80120-31, 80134-35, 80137-38, 80150-51, 80154-55, 80160-63, 80201-12, 80214-39, 80241, 80243-44, 80246, 80248-52, 80254-56, 80259-66, 80270-71, 80273-75, 80279-81, 80290-95, 80299, 80301-10, 80314, 80321-23, 80328-29, 80401-3, 80421-22, 80425, 80427, 80433, 80437, 80439, 80452-55, 80457, 80465-66, 80470-71, 80474, 80481, 80501-4, 80510, 80513-14, 80516, 80520, 80530, 80533-34, 80537-40, 80542-44, 80601-3, 80614, 80621, 80623, 80640, 80642-43, 80651.

Colorado Springs. These zip codes in Douglas, El Paso, Fremont, Park and Teller counties: 80106, 80118, 80132-33, 80808-09, 80813-14, 80816-17, 80819-20, 80827, 80829, 80831-33, 80840-41, 80860, 80863-64, 80866, 80901, 80903-22, 80925-26, 80928-37, 80940-47, 80949-50, 80960, 80962, 80970, 80977, 80995, 80997, 81007-08, 81212, 81240.

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente service area, you can receive virtually all of the benefits of this Plan at any other Kaiser Permanente facility. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described on page 40; and for emergency care obtained from any non-Plan provider, as described on page 31. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents permanently reside outside of the area, you should consider enrolling in another plan. If you or a family member move, you do not have to wait until Open Season to change plans. Contact you employment or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from Plan providers will be the same with regard to coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Your mental health and substance abuse benefits have been changed to reflect this requirement.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling 303/344-7298. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  •• Speak up if you have questions or concerns.

  •• Keep a list of all the medicines you take.

  •• Make sure you get the results of any test or procedure.

  •• Talk with your doctor and health care team about your options if you need hospital care.

  •• Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 7.8% for Self Only or 7.7% for Self and Family.
- We increased the copay for after-hours/urgent care visits from $10 to $25 per visit.
- Oxygen is provided while traveling outside the service area.
- We increased the copay for brand-name prescription drugs to $15 per prescription or refill. The copay for generic prescription drugs remains at $5.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 303/338-3800.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments or coinsurance, and you will not have to file claims.

· **Plan providers**

Denver/Boulder area: We contract with the Colorado Permanente Medical Group, P.C., to provide or arrange all necessary health care services. Physicians, including specialists, and other health care professionals such as nurse practitioners, physician assistants, and other skilled medical personnel working as medical teams at our Plan facilities provide your medical care. You also receive other necessary medical services, such as physical therapy, laboratory and x-ray services at our Plan facilities.

We list Plan physicians in our provider directory, which we update periodically. The list is also on our website, www.kaiserpermanente.org.

Colorado Springs area: We contract, through the Colorado Permanente Medical Group, P.C., with a panel of affiliated primary care physicians, specialists, and other health care professionals to provide medical services. You can identify these physicians, along with a listing of affiliated specialists and ancillary providers in the Affiliated Practitioner Directory. You may obtain a copy by calling Customer Service at 888/681-7878 or going to our website, www.kaiserpermanente.org/coloradosprings and clicking on "Affiliated Practitioner Directory."

· **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members.

Denver/Boulder area: Our contracted hospitals include Exempla St. Joseph's Hospital, Swedish Medical Center and Boulder Community Hospital.

We offer health care at 16 Plan medical offices conveniently located throughout the Denver metropolitan area. We list these in the provider directory, which we update periodically. The list is also on our website.

Colorado Springs area: You may access hospital care at affiliated Plan facilities.

When you select your primary care physician, you will receive your services at that physician's office.

You must receive your health services at affiliated Plan facilities, except if you have an emergency. If you are visiting another Kaiser Permanente service area, you may receive health care services at those Kaiser Permanente facilities. Under the circumstances specified in this brochure, you may receive follow-up or continuing care while you travel anywhere.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

Denver/Boulder area: Choose your primary care physician from our provider directory. If you want to receive care from a specific physician who is listed in the directory, call the physician to verify that he or she still participates with the Plan and is accepting new patients.

Colorado Springs area: Choose your primary care physician from our panel of affiliated primary care physicians. Our affiliated physicians, both primary care and specialists, are listed in the Affiliated Practitioner Directory. You may obtain a copy by calling the Customer Service Center at 888/681-7878 or by going to our website, www.kaiserpermanete.org/coloradosprings and clicking on "Affiliated Practitioner Directory".

· **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. We cover specialists' services only when your primary care physician refers you.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

In Colorado Springs, you may change your primary care physician at any time. Call the Customer Service Center at 888/681-7878. Notify us of your new primary care physician choice by the 15th day of the month. Your selection will be effective for the first day of the following month.

· **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see a gynecologist or receive mental health services without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause; or

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or

  - reduce our service area and you enroll in another FEHB plan;

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

· **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, for Denver/Boulder members, call our Customer Service Center immediately at 303/338-3800, or for Colorado Springs members, 888/681-7878. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center; or

- the day your benefits from your former plan run out; or

- the 92nd day after you become a member of this Plan,

whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. However, for certain services, such as oral and maxillofacial surgery, reconstructive surgery, DME, and pulmonary rehabilitation, your physician must obtain approval from us.

We call this review and approval process "preauthorization." Preauthorization is the process of collecting information so we can determine coverage, eligibility, medical appropriateness, and benefit limitations.

Preauthorization determinations are made based on the information available at the time the service or procedure is requested.

Registered nurses perform the first level of review using nationally recognized guidelines and resources, as well as our own internal guidelines and policies. The nurse coordinates with the requesting physician in evaluating the medical appropriateness of the service or procedure. The Utilization Management nurse will approve cases that meet our criteria. If the nurse is unable to approve the services based on the application of our criteria, the Medical Director will review the matter. If the Medical Director approves, you will receive the service. If the Medical Director denies the service we send a denial letter to your physician and you.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

· **Copayments**	A copayment is a fixed amount of money you pay to the provider when you receive services. Example: When you see your primary care physician, you pay a copayment of $10 per office visit.
· **Deductible**	We do not have a deductible. NOTE: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.
· **Coinsurance**	Coinsurance is the percentage of our allowance that you must pay for certain services you receive. Example: In our Plan, you pay 50% of our allowance for infertility services.
• **Fees when you fail to make your copayment**	If you do not pay your copayment at the time you receive services, we will bill you. You will be required to pay a $10 charge for each bill sent for unpaid services.

Your out-of-pocket maximum for copayments and coinsurance

After your copayments and coinsurance total $2,000 per person or $4,500 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services.

- Prescription drugs
- Dental services
- Cosmetic services
- Chiropractic services
- Extended care services
- Durable medical equipment
- External prostheses and braces
- The $25 charges paid for follow-up or continuing care

Be sure to keep accurate records of your copayments and coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page63 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 303/338-3800 or at our website at www.kaiserpermanente.org.

Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary. • Plan physicians must provide or arrange your care. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	**You pay**
Professional services of physicians and other health care professionals • In a physician's office • Office medical consultations • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Second surgical option	$10 per office visit
Professional services of physicians and other health care professionals • In a Plan urgent care center during office hours • In a Plan urgent care center after office hours	$10 per office visit $25 per office visit
Professional services of physicians and other health care professionals • During a hospital stay	Nothing
At home	Nothing

Lab, X-ray, and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Cat scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services on the same day as your office visit $10 if you receive the services at any other time
Preventive care, adult	
Routine screenings, such as: • Blood lead level • Total blood cholesterol – once every three years, ages 19 through 64 • Colorectal cancer screening, including •• Fecal occult blood test •• Sigmoidoscopy, screening – every five years starting at age 50 • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older • Routine pap test Note: You will pay only one copayment if you receive your routine screening on the same day as your office visit.	$10 per office visit
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years Note: In addition to routine screening, we cover mammograms when medically necessary to diagnose or treat your illness.	Nothing
Routine immunizations and boosters	Nothing

Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance* • *Attending schools* *Travel immunizations*	*All charges*
Preventive care, children	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: •• Eye exams through age 17 to determine the need for vision correction •• Ear exams through age 17 to determine the need for hearing correction • Well-child care including routine examinations and immunizations	$10 per office visit Nothing for inpatient services
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance* • *Attending schoosl or camp* *Travel immunizations*	*All charges*
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your physician will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c) for hospital benefits and Section 5(b) for surgery benefits.	$10 per office visit

Maternity care	You pay
Not covered: • *Routine sonograms to determine fetal age, size, or sex*	*All charges*
Family planning	
• Family planning services including counseling • Voluntary sterilization Note: We cover surgically implanted contraceptives, injectable contraceptive drugs, and intrauterine devices (IUDs) under your Prescription Drug benefit.	$10 per office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	
Medical services for diagnosis of involuntary infertility. Treatment of involuntary infertility including artificial insemination limited to intrauterine insemination (IUI).	50% of our allowance
Not covered: • *Intravaginal insemination (IVI)* • *Intracervical insemination (ICI)* • *Assisted reproductive technology (ART) procedures, such as:* ‥ *in vitro fertilization* ‥ *gamete and zygote intrafallopian transfer (GIFT and ZIFT)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm and donor eggs and services related to their procurement and storage* • *Drugs related to infertility treatment*	*All charges*
Allergy care	
• Testing and treatment • Allergy injection	$10 per office visit
Allergy serum	Nothing

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: We limit high dose chemotherapy in association with autologous bone marrow transplants to those transplants listed under Organ/Tissue Transplants on page 27. • Respiratory and inhalation therapy • Dialysis Note: We waive office visit charges if you enroll in Medicare Part B and assign your Medicare benefits to us. Note: Intravenous (IV)/Infusion Therapy – we cover home IV and antibiotic therapy and growth hormone therapy (GHT) under the Prescription Drug benefit.	$10 per office visit
Not covered: • *Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered*	*All charges*
Rehabilitative therapies	
Two consecutive months of therapy per condition: • Physical therapy by qualified physical therapists to restore bodily function when you have a total or partial loss of bodily function due to illness or injury • Speech therapy by speech therapists to restore speech when you have a total or partial loss of functional speech due to illness or injury • Occupational therapy by occupational therapists to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life Note: If you have not received 20 or more outpatient visits within the two-month period that started with your first visit to a therapist, we may continue your therapy for up to 20 outpatient visits per therapy per condition.	$10 per office visit
Cardiac rehabilitation in a Multifit Intervention Program that provides exercise stress testing, exercise prescriptions, home self-monitored exercise and case management by registered nurses. Four educational sessions in "Cardiac College" to learn about diet, exercise, lipids, smoking cessation, and on-site monitored programs.	$10 per office visit

Pulmonary rehabilitation. The program consists of: • Initial evaluation • 6 education sessions • 12 exercise sessions • A final evaluation Note: You must complete the course within a two to three-month period.	$50 for the program
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	**You pay**
• Exam to determine the need for hearing correction • Hearing testing for children through age 17 (see Preventive care, children)	$10 per office visit
Not covered: • *All other hearing testing* • *Hearing aids and supplies*	*All charges*
Vision services (testing, treatment, and supplies)	
• Diagnosis and treatment of diseases of the eye • Eye exam to determine the need for vision correction for children through age 17 (see Preventive care, children) • Eye refractions to provide a written lens prescription for eyeglasses only	$10 per office visit
Not covered: • *Corrective eyeglass lenses or frames* • *Examinations for contact lenses or the fitting of contact lenses* • *Eye exercises* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$10 per office visit

Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails and similar routine treatment of conditions of the foot* • *Treatment of weak, strained or flat feet or bunions or spurs of any instability, imbalance or subluxation of the foot*	*All charges*
Orthopedic and prosthetic devices	**You pay**
When prescribed by a Plan physician, we cover: • Artificial legs, arms and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome Note: We will pay no more than $2000 per year. The $2000 limit does not apply to artificial arms and legs. Note: We cover only those standard items that are adequate to meet the medical needs of the member.	20% of our allowance
Not covered: • *Comfort, convenience, or luxury equipment or features* • *Orthopedic and corrective shoes* • *Podiatric use devices and arch supports* • *Foot orthotics* • *Dental prostheses, devices, and appliances* *Note: We will provide medically necessary orthodontic and prosthodontic treatment for cleft lip or cleft palate for newborn members, unless these services are covered under a dental insurance policy.* • *Spare or alternate use devices* • *Replacement of lost prosthetic and orthotic devices* • *Repairs, adjustments, or replacements because of misuse* • *Devices, equipment and prosthetics related to treatment of sexual dysfunction*	*All charges*

Durable medical equipment (DME)	You pay
When prescribed by a Plan physician, we cover rental or purchase, at our option, of durable medical equipment intended to be used repeatedly and in the home. Covered items include: • Oxygen and oxygen equipment • Dialysis equipment • Infant apnea monitors • Insulin pumps for Type 1 diabetes • Hospital beds • Wheelchairs, including motorized wheelchairs when medically necessary • Crutches • Walkers • Commodes • Respirators • Blood glucose monitors • Repair and adjustment Note: We will pay no more than $2000 per year for all DME. Oxygen and insulin pumps are not subject to the $2000 limit. When outside the service area, you must obtain your oxygen supplies and services from Apria. Note: We cover only those standard items that are adequate to meet the medical needs of the member. Note: We use a DME formulary to determine which items will be provided to members.	20% of our allowance

Not covered: • *Comfort, convenience, or luxury equipment or features* • *Devices, equipment, supplies, and prosthetics related to the treatment of sexual dysfunction* • *Electric monitors of bodily functions* • *Devices to perform medical testing of bodily fluids, excretions, or substances* • *Devices not medical in nature such as whirlpools, saunas, elevators, convenience, or comfort items* • *Disposable supplies* • *Replacement of lost equipment* • *Repair, adjustments, or replacements because of misuse* • *More than one piece of durable medical equipment serving essentially the same function, except for replacements* • *Spare or alternate use equipment*	*All charges*
Home health services	**You pay**
If you are homebound and reside in the service area: • You may receive home health services of nurses and health aides, physical or occupational therapists, and speech and language pathologists • Services include oxygen therapy, intravenous therapy, and medications	Nothing
Not covered: • *Custodial care* • *Homemaker services* • *Care that a Plan physician determines may appropriately be provided at a Plan Medical Office, hospital, or skilled nursing facility* • *Services outside our service area*	*All charges*

Alternative treatments	
Chiropractic services, limited to 20 visits per calendar year: • Evaluation • Associated laboratory • X-ray services • Treatment of musculoskeletal disorders Note: You may self-refer to one of our participating chiropractors. For a list of participating chiropractors contact our Customer Service Center in the Denver/Boulder area at 303/338-3800 or in the Colorado Springs area at 888/681-7878.	$15 per office visit
Alternative treatments	**You pay**
Not covered chiropractic services: • *Treatment for non-neuroskeletal disorders* • *Vocational rehabilitation services* • *Thermography* • *Transportation costs, including ambulance* • *Prescription drugs, vitamins, minerals, nutritional supplements, or other similar type products* • *MRI or other types of diagnostic radiology* • *Durable medical equipment or supplies for use in the home*	*All charges*
Other services not covered: • *Naturopathic services* • *Hypnotherapy* • *Acupuncture* • *Biofeedback*	*All charges*
Educational classes and programs	
Health education services and education in the appropriate use of Health Plan services	$10 per office visit
Health education classes, such as smoking cessation, stress reduction, or weight control	The specific charge we set for the class you select

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary. • Plan physicians must provide or arrange your care. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). • **YOU MUST GET PREAUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the pre-authorization information shown in Section 3 to be sure which services require pre-authorization and identify which surgeries require pre-authorization.	IMPORTANT

Benefit Description	You pay
Surgical procedures	**You pay**
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity • Insertion of internal prosthetic devices. See Section 5(a) orthopedic braces and prosthetic devices for coverage information. • Voluntary sterilization (tubal ligation and vasectomy) • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs). Note: Devices are covered under Section 5(a). • Treatment of burns	$50 for outpatient surgery Nothing for inpatient procedures

Surgical procedures	You pay
Not covered: • *Reversal of voluntary sterilization* • *Implants or devices related to the treatment of sexual dysfunction*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance; and •• the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities, cleft lip, cleft palate, birthmarks, webbed fingers, and webbed toes. • Surgery for treatment of a form of congenital hemangioma known as port wine stains on the face or neck of members 18 years or younger • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; and •• breast prostheses and surgical bras and replacements (see Prosthetic devices). Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$50 per outpatient surgery Nothing for inpatient procedures
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	$10 per office visit
Not covered: • *Shortening of the mandible or maxillae for cosmetic purposes* • *Correction of malocclusion* • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental care involved in treatment of the temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/Lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Note: We cover related medical and hospital expenses of the donor when we cover your transplant.	$50 per outpatient surgery Nothing for inpatient procedures
Organ/tissue transplants	**You pay**
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of non-human or artificial organs* • *Bone marrow transplants associated with high dose chemotherapy for other solid tissue tumors* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office	Nothing

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

	IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary. • Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).	**IMPORTANT**

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • Semiprivate accommodations, or when a Plan physician determines it is medically necessary, private accommodations or private duty nursing care • Specialized care units such as intensive or cardiac care units • General nursing care • Meals and special diets Note: Your physician may prescribe private accommodations or private duty nursing care if it is medically necessary. If you want at private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing

Inpatient hospital	You pay
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The conditions for which we will provide hospitalization include hemophilia and heart disease. The need for anesthesia, by itself, is not such a condition. We cover general anesthesia for dental services for a member's child due to physical, mental, or behavior problems.	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals, and beds* • *Any inpatient dental procedures*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	$50 per surgery

Extended care benefits/skilled nursing care facility benefits	You pay
Up to 100 days per calendar year • When full-time skilled nursing care is necessary • Confinement in a skilled nursing facility is medically appropriate	Nothing
Not covered: • *Custodial care* • *Care in an intermediate care facility*	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member: • You must reside in the service area • Services are provided in the home, or • In a Plan approved hospice facility. Services include inpatient care, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less. Note: Hospice is a program for caring for the terminally ill that emphasizes supportive services, such as home care and pain control, rather than curative care of the terminal illness. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, physician services, and short-term inpatient care for pain control and acute and chronic symptom management. We also provide counseling and bereavement services for the individual and family members, and therapy for purposes of symptom control to enable the person to continue life with as little disruption as possible. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.	Nothing
Ambulance	
Local professional ambulance service when ordered or authorized by a Plan physician	$25 per transport
Not covered: • *Transports that we determine are not medically necessary*	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	IMPORTANT

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In a life-threatening emergency, call 911. When the operator answers, stay on the phone and answer all questions.

Emergencies within our service area:

Denver/Boulder area: If you are in an emergency situation, call **911**, go to the closest emergency room or a Plan hospital. If you are not sure whether your situation is an emergency, call our Emergency Care Telephone Line at 303/861-3434, 24 hours a day, seven days a week. If an ambulance is necessary, we will authorize it.

For urgently needed services, such as an earache or sore throat with fever that cannot wait for a routine visit, you may call your PCP's Medical Office to schedule a same-day appointment during regular office hours. You may obtain urgent care services after regular office hours at various facilities in the Denver/Boulder area. Please call 303/338-3800 for information on locations and hours of accessibility for after-hours/urgent care.

Colorado Springs area: If you are in an emergency situation, call 911, or go to the closest emergency room. If you are not sure your situation is an emergency, call your PCP.

For urgent care that cannot wait for a routine office visit, call your PCP to schedule a same-day or urgent care appointment during regular office hours. Urgent/after hours care is available by calling your PCP. You can also check our Web site, www.kaiserpermanente.org/coloradosprings, for a listing of urgent care/after hours clinics.

Emergencies outside our service area:

We cover emergency situations, such as myocardial infarction, appendicitis or premature delivery, outside the service area. If you are hospitalized for emergency services while outside our service area, you or a family member should notify us within 48 hours or as soon as possible after you have been admitted. We will make arrangements for any necessary continued hospitalization or to transfer you to a hospital within our Plan. By notifying us as soon as possible, you will protect yourself from potential liability for payment of services you receive after a transfer would have been possible.

Note: Emergency services are limited to those services required before your medical condition permits your travel or transfer to care in our Plan. Continuing or follow-up care from out-of-plan providers is not covered.

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities are listed in the local telephone book under Kaiser Permanente. These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling Customer Service at 303/338-3800.

Benefit Description	You pay
Emergency within our service area	**You pay**
Emergency care as an outpatient or inpatient at a hospital, including physicians' services	
• At a Plan medical office	$10 per visit
• After hours/urgent care services	$25 per visit
• In a hospital emergency room	$50 per visit
Note: Your copayment is waived if you are admitted to a Plan hospital.	
Not covered:	*All charges*
• *Elective care or non-emergency care*	
Emergency outside our service area	
Emergency care as an outpatient or inpatient at a hospital, including physicians' services	
• Urgent care services	$25 per visit
• In a hospital emergency room	$50 per visit
• In a Kaiser Foundation hospital in another Kaiser Foundation Health Plan service area	The amount you would be charged if you were a member in that service area
Note: See the Travel Benefit for coverage of continuing or follow-up care.	
Not covered:	*All charges*
• *Elective care or non-emergency care*	
• *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	
• *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	
Ambulance	
• Professional ambulance services to the nearest hospital equipped to handle your medical condition where authorized by a Plan physician.	$25 per transport
• We will authorize air ambulance if ground transportation is not medically appropriate	
Not covered:	*All charges*
• *Transports that we determine are not medically necessary*	

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT

Parity

Beginning in 2001, all FEHBP plans' mental health and substance benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
We cover all diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: We cover the services only when we determine that the care is clinically appropriate to treat your condition, and only when you receive the care as part of a treatment plan developed by a Plan provider. Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment in favor of another.	Your cost sharing responsibilities are not greater than for other illnesses or conditions

Diagnosis and treatment of psychiatric conditions for children, adolescents, and adults. Services include: • Diagnostic evaluation • Psychiatric treatment, including group and individual therapy • Medication evaluation and management Diagnosis and treatment of alcoholism and drug abuse. Services include: • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) • Rehabilitative care Note: Your mental health or substance abuse provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse. Note: You may see a mental health provider for these services without a referral from your primary care physician.	$10 per office visit
• Inpatient psychiatric care • Hospital alternative services, such as partial hospitalization, day and night care, and intensive outpatient psychiatric treatment programs • Inpatient care Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan physician.	Nothing

Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Continued services if you do not substantially follow your treatment plan* • *Services we have not approved* • *Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* • *Services that are custodial in nature* • *Services rendered or billed by a school or a member of its staff* • *Services provided under a federal, state, or local government program* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms*	*All charges*

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage. The transitional period will last for up to 90 days from the date you receive notice of the change. You may receive this notice prior to January 1, 2001, and the 90-day period begins with receipt of the notice.

Benefit limitation

We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

There are important features you should be aware of. These include:

- **Who can write your prescription**. A Plan or referral physician or licensed dentist must write the prescription.
- **Where you can obtain them**.

  Denver/Boulder area: You must fill the prescription at a Plan pharmacy. You may refill prescriptions through Direct Rx**,** our mail order service. We provide refills in the same quantities as the original prescription, up to a 60-day supply. You can obtain reorder envelopes at Plan pharmacies. Envelopes are included in every order mailed by Direct Rx. Direct Rx mails refills by First Class U.S. Mail at no charge to you for postage and handling. You should receive your prescription within 7-10 days. To place an order by telephone, call Direct Rx at 303/344-7986. This refill line can be used 24 hours a day.

  Colorado Springs area: You must fill the prescription at a pharmacy designated by the Plan. A list of affiliated pharmacies can be obtained by calling our Customer Service Center at 888/681-7878 or by accessing our Colorado Springs website at www.kaiserpermanente.org/coloradosprings. You may have prescriptions for maintenance medications filled by our convenient mail-order prescription service, ***family*meds**, available 24 hours a day. Refills will be mailed by First Class U.S. Mail at no charge to you for postage and handling. You should receive your prescription within 7-10 days. Contact ***family*meds** at 888/787-2800 for more information, or check our Colorado Springs website.

- **We use a formulary**. A formulary is a listing of preferred pharmaceutical substances and formulas. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. When your physician believes a non-formulary drug is necessary, he may request a formulary exception. The physician, pharmacist, and our medical director will determine the best medication to treat your condition. If you request the non-formulary drug when your Plan physician has prescribed a generic substitution, the non-formulary drug will not be covered. However, you may purchase the non-formulary drug from a Plan pharmacy or designated pharmacies in the Colorado Springs area at our allowance.

  Note: Some prescription drugs, such as (but not limited to) Zyban or Interferon, require preauthorization in Colorado Springs. Your Plan physician should contact MedImpact, our pharmacy benefit manager, or our medical director to obtain approval.

- **These are the dispensing limitations.** You may purchase covered drugs in prescribed quantities for up to a 60-day supply for maintenance drugs or part of a 60-day supply for non-maintenance drugs. Refills of prescriptions will be provided subject to the same conditions as the original prescription. Plan pharmacies may substitute a generic equivalent for a name-brand drug unless prohibited by the Plan physician. If a generic equivalent is not available, you pay the brand-name copay. If you request a brand-name drug not on the formulary when your Plan physician has prescribed an approved generic drug, you pay the applicable copay plus the difference in price between the generic drug and your requested brand-name drug.

- **When you have to file a claim.** When you receive drugs from a Plan pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below • Oral and injectable contraceptive drugs, contraceptive devices, and intrauterine devices • Insulin • Growth hormone • Niacin • Chemotherapy drugs Note: If we do not have a generic equivalent for a brand name drug, you will pay the $15 copay.	$5 per prescription for generic drugs $15 per prescription for brand-name drugs
• Disposable needles and syringes for the administration of covered medications • Glucose test strips • Injections of Lupron Depot (in place of surgery for prostate cancer)	20% of our allowance
• Implanted time-release drugs such as Norplant Note: We do not refund any portion of the copayment if you request removal of the implanted time-release medication before the end of its expected life.	A one-time payment equal to $5 times the expected number of months the medication will be effective, not to exceed $200
Food supplements and supplies, for use in the home • For individuals unable to absorb or digest food • Includes enteral and parenteral elemental dietary formulas and amino acid modified product for treatment of inborn errors of metabolism	$3 per day
• Drugs to treat sexual dysfunction Note: There are dispensing limitations for drugs to treat sexual dysfunction. Please contact us for details.	50% of our allowance
• Immunosuppressant drugs after a covered transplant • Intravenous fluids and medications for home use	Nothing

Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Vitamins and nutritional supplements that can be purchased without a prescription* • *Medical supplies such as dressings and antiseptics* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs related to infertility services* • *Condoms*	*All charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit • We review alternative benefits on an ongoing basis • By approving an alternative benefit, we cannot guarantee you will get it in the future • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process
Travel benefit	Kaiser Permanente's travel benefits for Federal employees provide you with outpatient follow-up or continuing medical care when you are outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency and urgent care benefits and include: • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast • Outpatient continuing care for conditions diagnosed by a Kaiser Permanente health care provider or affiliated Plan provider that have been treated within the previous 90 days. Services include childhood immunizations, dialysis, or prescription drug monitoring • You pay $25 for each follow-up or continuing care office visit. We deduct this amount from the payment we make to you • We pay no more than $1200 each calendar year • For more information about this benefit call the Travel Benefit Information Line at 800/390-3509 • Claims should be submitted to the Claims Department, Kaiser Foundation Health Plan of Colorado, P.O. Box 372970, Denver, CO 80237-6970 (Denver/Boulder area) and the Claims Department, Kaiser Foundation Health Plan of Colorado, P.O. Box 378020, Denver, CO 80237-8020 (Colorado Springs) *The following are not included in your travel benefits coverage:* • *Non-emergency hospitalization* • *Infertility treatments* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* • *Transplants* • *Prescription drugs (you may have prescriptions filled by mail through our Prescription Drug Benefit)*

Services from other Kaiser Permanente Plans

When you visit the service area of another Kaiser Permanente plan, you are entitled to receive virtually all the benefits described in this brochure at any Kaiser Permanente medical office or medical center. You will have to pay the copayments or other charges imposed by the Plan you are visiting. If the Plan you are visiting has a benefit that differs from the benefits of this Plan, you are not entitled to receive that benefit.

Some services covered by this Plan, such as artificial reproductive services and the services of specialized rehabilitation facilities, will not be covered if you receive them in other Kaiser Permanente service areas. If a benefit is limited to a specific number of visits or days, you are entitled to receive only the number of visits or days covered by this Plan.

If you are seeking routine, non-emergent, or non-urgent services, you should call the Kaiser Permanente Membership Services department in that service area and request an appointment. You may obtain routine follow-up or continuing care from these Plans, even when you have obtained the original services in our service area. If you require emergency services as the result of unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care.

At the time you register for services, you will be asked to pay the charges required by the local Plan.

If you wish to obtain more information about the benefits available to you from a Kaiser Permanente Plan in an area you visit, please call the Customer Service Center at 303/338-3800 in Denver/Boulder and 888/681-7878 in Colorado Springs.

Section 5 (h). Dental benefits

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover only when we determine they are dentally necessary. • Plan dentists must provide or arrange your care. • We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure unless it is described below. • Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • For a list of participating providers, please contact Delta Dental Plan of Colorado at 303/741-9305 or 800/610-0201.	IMPORTANT

Accidental injury benefit	You pay
We cover emergency services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Any other services are provided as described below.	Nothing for inpatient services; $10 for outpatient services

Dental Benefits

Service	You pay
Diagnostic	
Initial Exam	$ 10.00
Periodic Exam	Nothing
Emergency Exam	18.00
Full Mouth X-Rays	35.00
1 Intraoral Xray	6.00
Additional Intraoral Xray	4.00
Occlusal Xray	10.00
Bitewing	5.00
2 Bitewings	11.00
3 Bitewings	11.00
4 Bitewings	15.00
Panoramic Film	28.00
Cephalometric Film	27.00
Pulp Tests	11.00
Diagnostic Casts	26.00

Service	You pay
Preventive	
Prophylaxis Adult	$ 5.00
Prophylaxis Age 0-14	5.00
Topical Fluoride W/Prophy	16.00
Top Fluoride Child No Prophy	5.00
Top Fluoride Adult No Prophy	5.00
Sealant - Per Tooth	9.00
Spacer Fixed Unilateral	85.00
Spacer Fixed Bilateral	130.00
Restorative	
Amalgam 1 Surface Primary	$ 29.00
Amalgam 2 Surface Primary	36.00
Amalgam 3 Surface Primary Amalgam 1	45.00
Surface Permanent	34.00
Amalgam 2 Surface Permanent	44.00
Amalgam 3 Surface Permanent	55.00
Amalgam 4 Surf/Plus Permanent	66.00
Anterior Resin 1 Surface	40.00
Anterior Resin 2 Surfaces	52.00
Anterior Resin 3 Surfaces	64.00
Porc/High Noble Metal Crown	365.00
Porc/Predom Base Metal Crown	312.00
Porc/Noble Metal Crown	348.00
Full High Noble Metal Crown	358.00
Full Predom Base Metal Crown	298.00
Full Noble Metal Crown	340.00
3/4 Metallic Crown	350.00
Recement Crown	26.00
Prefab Stainless Steel Crown Primary	76.00
Sedative Filling	26.00
Crown Buildup Pin Retained	75.00
Pin Retention Excl Of Restoration	16.00
Cast Post & Core In Add To Crown	118.00
Prefab Post & Core No Crown	95.00

Service	You pay
Endodontics	
Therapeutic Pulpotomy	$ 45.00
Root Canal Anterior	195.00
Root Canal Bicuspid	230.00
Root Canal Molar	310.00
Apicoectomy Anterior	190.00
Apicoectomy Bicuspid	230.00
Apicoectomy Molar	235.00
Periodontics	
Gingivectomy Per Quad	$ 148.00
Gingivectomy Per Tooth	58.00
Gingival Curettage Per Quad	144.00
Gingv Flap W/Root Pl-Per Quad	250.00
Osseous Surgery Per Quad	640.00
Perio Root Plan Per Quad	84.00
Maintenance Following Therapy	44.00

Service	You pay
Prosthodontics	
Complete Upper Denture	$ 423.00
Complete Lower Denture	423.00
Comp Immediate Upper Denture	455.00
Comp Immediate Lower Denture	455.00
Partial Upper Denture/Metal Base	490.00
Partial Lower Denture/Metal Base	490.00
Repair Broken Complete Denture	55.00
Replace Missing/Broken Teeth	50.00
Repair/Replace Broken Clasp	72.00
Replace Tooth on Denture	50.00
Add Tooth to Partial Denture	60.00
Add Clasp to Partial Denture	72.00
Lab Reline Upper Denture	95.00
Lab Reline Lower Denture	95.00
Cast High Noble Metal Pontic	360.00
Cast Predom Base Metal Pontic	265.00
Cast Noble Metal Pontic	280.00
Porcelain With High Noble Metal Pontic	375.00
Porcelain Predom Base Metal Pontic	260.00
Porcelain Noble Metal Pontic	275.00
Porcelain High Noble Metal Crown	380.00
Porcelain Predom Base Metal Crown	265.00
Porcelain Noble Metal Crown	355.00
Full High Noble Metal Crown	370.00
Full Predom Base Metal Crown	250.00
Full Noble Metal Crown	285.00
Cast Pore & Core No Bridge Retainer	100.00
Prefabricated Post & Core No Bridge	80.00
Retainer Crown Build-Up	65.00

Service	You pay
Oral Surgery	
Single Tooth Extraction	$ 38.00
Additional Tooth Extraction	34.00
Root Removal Exposed Tooth	48.00
Surgery Extraction/Erupted Tooth	74.00
Rem Imp Tooth-Soft Tissue	85.00
Rem Imp Tooth-Partially Bony	110.00
Rem Imp Tooth-Completely Bony	130.00
Surgical Root Recovery	75.00
Adjunctive Services	
Palliative Treatment	$ 30.00
Consultation	27.00
Emergency dental benefit – outside service area only	All amounts over $50
Not covered: • *Cosmetic dental services* • *Replacement of lost or stolen dentures or bridgework* • *Orthodontic services* • *Dental services not listed as covered*	*All charges*

Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

As an FEHBP enrollee in this Plan, you can receive acupuncture and massage therapy services through Landmark Healthcare, at a 25% discount of the practitioner's standard charges. Contact Landmark Healthcare at 800/638-4557 for more information.

Section 6. General exclusions -- things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan physician determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Section 5(d)), services under the Travel Benefit (see Section 5(g)), and services received from other Kaiser Permanente plans (see Section 5(g));
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs, or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or fill your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers or when you use the travel benefit. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital, and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 303/338-3600 in Denver/Boulder and 888/681-7878 in Colorado Springs.

When you must file a claim – such as for out-of-area care – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Denver/Boulder area:
Claims Department
Kaiser Foundation Health Plan of Colorado
P.O. Box 372970
Denver, CO 80237-6970

Colorado Springs area:
Claims Department
Kaiser Foundation Health Plan of Colorado
P.O. Box 378020
Denver, CO 80237-8020

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

If you have a malpractice claim

If you have a malpractice claim because of services you did receive, or did not receive, from a Plan provider, you must submit the claim to binding arbitration. The Plan has the information that describes the arbitration process. Contact our Risk Management Department at 303/344-7298 for copies of our requirements. These will explain how you can begin the binding arbitration process.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for pre-authorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Compliance and Risk Management Department, Kaiser Foundation Health Plan of Colorado, 10350 East Dakota Avenue, Denver, CO 80231-1314; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request -- go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, DC 20044-0436.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 303/338-3800 in the Denver/Boulder area and 888/681-7878 in the Colorado Springs area and we will expedite our review; or

(b) We denied your initial request for care or pre-authorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' Guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. If we are the secondary payer, and you received your services from Plan providers, we may bill the primary carrier.

- **What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

- **The Original Medicare Plan**

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. We will not waive any of our copayments.

(Primary payer chart begins on next page.)

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or …… b) The position is not excluded from FEHB…… Ask your employing office which of these applies to you.	……..…..✓ ……..	……✓
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or…… b) Are an active employee……	……..✓ ……..	……✓

· **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan, known as Medicare+Choice or Kaiser Permanente Senior Advantage, and also remain enrolled in our FEHB plan. (This Plan is available in the Denver/Boulder area only. It is not available in the Colorado Springs area.) In this case, we waive some of our copayments and coinsurance for your FEHB and Medicare coverage. If you would like information about our Medicare+Choice plan, please call 303/338-3800. Your Kaiser Permanente Senior Advantage-FEHBP benefits are:

- Outpatient office visits: $0
- Preventive care office visits: $0
- Short-term speech, occupational, and physical rehabilitative therapy: $0
- Outpatient mental health: first 20 office visits $0, additional office visits $5
- Inpatient mental health: $0
- Dialysis services: $0
- Family planning services: $0
- Infertility treatment: $0
- Substance abuse treatment: $0

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary if you use our Plan providers, but we will not waive any of our copayments or coinsurance.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care service area.

· **Enrollment in Medicare Part B**

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting, and taking medicine. (2) Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or investigational services

We carefully evaluate whether a particular therapy is safe and effective or offers a reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental literature. When the service or supply, including a drug: (1) has not been approved by the FDA; or (2) is the subject of a new drug or new device application on file with the FDA; or (3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or (4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or (5) is subject to the approval or review of an Institutional Review Board; or (6) requires an informed consent that describes the service as experimental or investigational; then this Plan considers that service, supply, or drug to be experimental, and not covered by the Plan.

Group health coverage

Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Health care coverage purchased through membership in an organization is also "group health coverage."

Medically necessary

All benefits need to be medically necessary in order for them to be covered benefits. Generally, if your Plan physician provides the service in accord with the terms of this brochure, it will be considered medically necessary. However, some services are reviewed in advance of your receiving them to determine if they are medically necessary. When we review a service to determine if it is medically necessary, a Plan physician will evaluate what would happen to you if you do not receive the service. If not receiving the service would adversely affect your health, it will be considered medically necessary. The services must be a medically appropriate course of treatment for your condition. If they are not medically necessary, we will not cover the services. In case of emergency services, the services that you received will be evaluated to determine if they were medically necessary.

Our allowance

The amount we use to determine your coinsurance. When you receive services or supplies from Plan providers, it is the amount that we set for the services or supplies if we were to charge for them. When you receive services from non-Plan providers, we determine the amount that we believe is usual and customary for the service or supply, and compare it to the charges. Our allowance is based upon the reasonableness of the charges. If the charges exceed what we believe is reasonable, you may be responsible for the excess over our allowance in addition to your coinsurance.

Us/We

Us and we refer to Kaiser Foundation Health Plan of Colorado.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

Coverage information

· **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

· **Where you get information about enrolling in the FEHB Program**

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

· **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

· **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

· **Your medical and claims records are confidential**

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

· **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

When you lose benefits

· **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

· **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

· **TCC**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of*

Coverage and Former Spouse Enrollees, from your employing or retirement office or from www.opm.gov/insure.

· **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

· **Getting a Certificate of Group Health Plan Coverage**

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us 303/338-3800 in Denver/Boulder or 888/681-7878 in Colorado Springs and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

· **Penalties for Fraud**

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for Kaiser Foundation Health Plan of Colorado – 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$10 per office visit	14
Services provided by a hospital:		28
• Inpatient	Nothing	
• Outpatient	$50 per surgery	29
Emergency benefits:		31
• In-area	$50 per visit	
• Out-of-area	$50 per visit	31
Mental health and substance abuse treatment:	Regular cost sharing	33
Prescription drugs	$5 per prescription for generic drugs; $15 for brand name	38
Dental Care	Various copays based on procedure rendered	42
Vision Care	One refraction annually; $10 per office visit	19
Special features: Flexible benefits option; Travel benefit; Services from other Kaiser Permanente Plans		40
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $2,000/Self Only or $4,500/Family enrollment per year Some costs do not count toward this protection	12

2001 Rate Information for
Kaiser Foundation Health Plan of Colorado

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	651	$65.11	$21.70	$141.07	$47.02	$77.04	$9.77
Self and Family	652	$166.02	$55.34	$359.71	$119.90	$196.46	$24.90