Kaiser Foundation Health Plan of Kansas City, Inc. 2001

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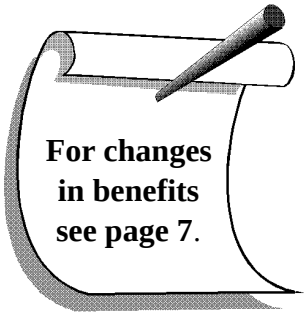
A Health Maintenance Organization



Serving: Kansas City Metropolitan Area
Kansas and Missouri

Enrollment in this Plan is limited; see page 6 for requirements.

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

Enrollment codes for this plan:

HA1 Self Only
HA2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees
Health Benefits Program

RI 73-128

Table of Contents

Introduction

Kaiser Foundation Health Plan of Kansas City, Inc.
10561 Barkley, Suite 200
Overland Park, Kansas 66212

This brochure describes the benefits of Kaiser Foundation Health Plan of Kansas City, Inc. under our contract (CS 1948) 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 Kansas City, Inc.

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, use specific hospitals, and obtain care from 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 individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers are paid in a number of ways including salary, capitation, per diem rates, case rates, fee for service, and incentive payments. If you would like further information about the way Plan physicians are paid to provide or arrange medical and hospital care, please call Member Services at 913/642-2662, or for the hearing impaired call 913/642-3696. You will only be responsible for your copayments or coinsurance.

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 Kansas City, Kansas and Missouri areas since 1985. Kaiser Foundation Health Plan of Kansas City, Inc. is a 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, Permanente Medical Group of Mid-America, P.A., operates Plan medical offices in the Kansas City, Kansas and Missouri areas.

If you want more information about us, call 913/642-2662, or write to Kaiser Foundation Health Plan of Kansas City, Inc., Attn: Member Services, Suite 200, Overland Park, KS 66212. You may also contact us by fax at 913/967-4630 or visit our website at www.kaiserpermanente.org/kansascity.

Service Area

To enroll in this Plan, you must live or work in the service area. The service area includes:

Kansas – Johnson, Leavenworth, and Wyandotte Counties

Missouri – Cass, Clay, Jackson, and Platte Counties

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 41; and for emergency care obtained from any non-Plan provider, as described on page 34. 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. Previously, we placed day or visit limitations on mental health and substance abuse services.
- 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 913/967-4702. 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 5.9% for Self Only or 5.8% for Self and Family.
- We provide one compression garment per year for cellulites as the result of lymphedema.
- Oxygen is provided while traveling outside the service area.
- We supply your prescription drug refills through mail order for a $2.00 delivery charge.
- We no longer charge a fee when you do not pay your copayment at the time you receive services.

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 Member Services at 913/642-2662, or for the hearing impaired call 913/642-3696.

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**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. Physicians who are part of the Permanente Medical Group of Mid-America, P.A., Lee's Summit Family Care Center, College Park Family Care, Belton Family Care, or Family Practice of Eastern Jackson County coordinate your medical care. The majority of our primary and specialty care physicians are board certified. That means they have met the educational and experience standards established by the national medical board in their primary specialty. We credential Plan providers according to state and national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. Our physician offices are located at Baptist Medical Office, Blue Ridge Medical Office, Northland Medical Office, Parallel Parkway Medical Office, and the Lee's Summit Family Care Center. In addition, services are provided at Belton Family Care and Family Practice of Eastern Jackson County. If you obtain your care from these facilities, your primary hospital will be Baptist Medical Center. If you receive your care from College Park Family Care, your primary hospital will be Overland Park Regional. We list Plan facilities in the provider directory, which we update periodically. The list is also on our website.

You must receive your health services at 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.

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Choose your primary care physician from our Plan provider directory. We update this directory on a regular basis and list the physicians' address, phone number, and if he or she is taking new patients. If you need a provider directory or assistance with choosing a primary care physician, please call Member Services at 913/642-2662, or for the hearing impaired call 913/642-3696. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see an obstetrician, gynecologist, optometrist, chiropractor, or a mental health provider 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 work with the Plan to 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 (the physician may have to get an authorization or approval beforehand).

- 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 it 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, call Member Services immediately at 913/642-2662, or for the hearing impaired call 913/642-3696. 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. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process prior authorization of services. Your physician must obtain authorization for services such as hospitalization, referral to a specialist outside the network, or recommendations for follow-up care.

If you do not get an authorization, your services may be denied, and you may have to pay the entire bill, or a large portion of the bill.

In addition, we may retract or refuse to pay an authorization, referral, or claims if:

- you make a material misrepresentation or omission about your health condition or the cause for your health conditions;
- your group terminates its contract before your health care services are provided; or
- your coverage under the group agreement terminates before the health care services are provided.

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 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 your care.

  Example: In our Plan, you pay 50% of our allowance for diagnosis and treatment of infertility.

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 or coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services:

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

Be sure to keep accurate records of your copayments or 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 page 63 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 913/642-2662 or for the hearing impaired 913/642-3696 or at our website at www.kaiserpermanente.org/kansascity.

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	
Professional services of physicians and other health care professionals • In a physician's office • Second surgical opinion • In an urgent care center	$10 per office visit
Professional services of physicians and other health care professionals • During a hospital stay • In a skilled nursing facility	Nothing
At home	Nothing
Lab, X-ray, and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Cat scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Preventive care, adult	You pay
Routine screenings, such as: • Routine physicals • Personal health appraisals • Well-woman exam to include one pap smear every year • Pelvic examination and pap smear for any non-symptomatic woman • Prostate examination and laboratory tests for cancer for any non-symptomatic man • Colorectal cancer screening, including ••Fecal occult blood test	Nothing
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
Not covered: *Physical exams and related services required for:* • *Obtaining or continuing employment* • *Insurance* • *Government licensing* • *Attending school* • *Travel*	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics, up to age 12 • Well-baby care and periodic wellness check-ups up to age six (6)	Nothing

• Immunizations from age 12 through 18 • Periodic wellness check-ups after age six (6) • Examinations, such as: •• Eye exam through age 17 to determine the need for vision correction •• Ear exam through age 17 to determine the need for hearing correction	$10 per office visit
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance* • *Attending schools or camp* *Travel immunizations*	*All charges*
Maternity care	**You pay**
First visit to confirm pregnancy	$10 copayment
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Lab, X-ray, and ultrasound 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	Nothing

Not covered: • *Routine sonograms to determine fetal age, size, or sex*	*All charges*
Family planning	
• Family planning and counseling • Birth control and counseling	$10 per office visit
Not covered: • *Genetic counseling*	*All charges*
Infertility services	
• Diagnosis and treatment of infertility • Outpatient lab and X-rays	50% of our allowance
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• Intravaginal insemination (IVI) •• Intracervical insemination (ICI) •• Intrauterine insemination (IUI)	50% of our allowance per procedure
Not covered: • *Cost of donor sperm and eggs and services related to their procurement and storage* • *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 or non-covered infertility treatment* • *Drugs and supplies for the treatment of infertility*	*All charges*
Allergy care	**You Pay**
• Testing and treatment • Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*

Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27 • Respiratory and inhalation therapy • Dialysis Note: We waive the $10 charge if you enroll in Medicare Part B and assign your Medicare benefits to the Plan. • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT)	$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	**You Pay**
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 is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction.	$10 per office visit
Pulmonary rehabilitation – up to twelve sessions	$50 flat fee
Not covered: • *Long-term rehabilitative or maintenance therapy* • *Exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Test to determine the need for hearing correction • For newborns, hearing screening, necessary rescreening, audiological assessment, and follow-up and initial amplification	$10 per office visit

Not covered: • *Tests to determine an appropriate hearing aid* • *External and internally implanted hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• Diagnosis and treatment of diseases of the eye • Eye refractions – to provide a written lens prescription for eyeglasses	$10 per office visit
Initial lenses following cataract surgery	Nothing
Not covered: • *Eye exercises and orthoptics* • *Corrective eyeglasses and frames or contact lenses (including the fitting of the lenses)* • *Examination for prescription of contact lenses* • *Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (Myopia), farsightedness (Hyperopia), and astigmatism*	*All charges*
Foot care	**You Pay**
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, except as stated above* • *Treatment of weak, strained, or flat feet or bunions or spurs, and of any instability, imbalance, or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Prosthetic device and installation accessories to restore a method of speaking following the removal of all or part of the larynx • 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. • Therapeutic footwear for severe diabetic foot disease in accord with Medicare guidelines • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome Note: Replacements are provided due to anatomical growth	Nothing up to $1,000 *All charges in excess $1,000 per calendar year*
Not covered: • *Comfort, convenience, or luxury equipment or features* • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Dental braces, devices, and appliances* • *Braces for aid in sports activities* • *Braces normally used as an aid for chronic conditions, such as chronic back pain, polio, multiple sclerosis, and spina bifida* • *Experimental and research braces* • *Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction* • *Replacement due to wear, tear, and misuse*	*All charges*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, of durable medical equipment, such as oxygen and dialysis equipment. We also cover items such as: • Hospital bed • Wheelchairs including motorized when medically necessary • Crutches • Walker • Blood glucose monitors • Infant apnea monitor • Cane • Oxygen while traveling when obtained from Apria (not subject to the annual benefit limit) • Orthopedic braces for scoliosis • Equipment required as a part of acute primary care such as back braces, rib belts, slings, and cervical collars • Replacement due to anatomical growth • Repair and adjustment of DME	Nothing up to $1,000 *All charges in excesss of $1,000 per calendar year*
One compression garment per year for patients with lymphedema who have developed cellulitis	20% of our allowance
Not covered: • *Comfort, convenience, or luxury equipment or features* • *Electric monitors of bodily functions, except for apnea monitors* • *Devices to perform medical testing of bodily fluids, excretions, or substances* • *Disposable supplies* • *Replacement of lost equipment* • *Repair, adjustment, or replacement necessitated by wear, tear, or misuse* • *More than one piece of durable medical equipment serving essentially the same function, except for replacements due to anatomical growth; spare equipment or alternate use equipment is not provided*	*All charges*

Home health services	You Pay
Part-time or intermittent nursing care: • Services will be provided by a registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), or home health aide • Services include oxygen therapy, intravenous therapy, and medications Other services include: • Drugs, supplies, and supplements • Physical, occupational, and speech therapy • Ostomy and urological supplies • Prosthetic and orthotic devices • Home IV and antibiotic therapy	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship, or giving oral medication* • *Nursing care that could appropriately be rendered in a Plan medical office, affiliated hospital, or skilled nursing facility* • *Nursing care that can be performed safely and effectively by people whom, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse* • *Services outside our service area*	*All charges*

Alternative treatments	You Pay
Chiropractic services – up to 20 visits per calendar year by the American Chiropractic Network. Covered services include: • Evaluation • Laboratory and x-ray • Treatment of musculoskeletal disorders Note: Contact us to get a list of chiropractors in the American Chiropractic Network. You may see a chiropractor without a referral.	$15 per office visit
Not covered chiropractic services: • *Non-neuroskeletal disorders* • *Vocational rehabilitation services* • *Thermography* • *Transportation costs including ambulance* • *Prescription drugs* • *Vitamins and minerals* • *Nutritional supplements or other similar type products* • *MRI or other type of diagnostic radiology*	*All charges*
Other services not covered: • *Acupuncture* • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*
Educational classes and programs	**You Pay**
Asthma – individual education in asthma During this one-on-one consultation you will learn: how the lungs work and how asthma affects your lungs, how to identify and avoid asthma triggers, how to identify early warning signs of asthma, how to use medication and treat symptoms.	Nothing
Diabetes – diabetic group consults This class is for people newly diagnosed with diabetes. You can learn: what diabetes is, what and when to eat, how to check your blood sugar at home, what to do when blood sugar is high or low, the role exercise plays in diabetes management, how to use your diabetes medication, how to take care of your feet. Please bring your diabetes packet (provided by Kaiser Permanente) and your blood sugar meter.	Nothing

Diabetes – individual education in diabetes This one-on-one consultation with a clinic nurse is for people newly diagnosed with diabetes. You can learn: what diabetes is, what and when to eat, how to check your blood sugar at home, what to do when blood sugar is high or low, the role exercise plays in diabetes management, how to use your diabetes medication, how to take care of your feet. Please bring your diabetes packet (provided by Kaiser Permanente) and your blood sugar meter.	Nothing
Heart and health – learning to live with CHF An interactive, one-hour class that will focus on your health and living with Congestive Heart Failure. In this education session you will learn about the following: proper diet, weight management, exercise, medications, signs and symptoms of heart-related problems, balancing activity and rest and tips for conserving your body's energy.	Nothing
Cholesterol management – cholesterol group consults This group consultation with a registered dietitian informs members: what lifestyle habits affect cholesterol, how to use fast food and convenience foods in a healthy way, how to read and understand food labels, how to keep track of fat in your diet.	$10 per office visit
Weight management – Self-Paced Weight Management kits Get started losing weight now with Kaiser Permanente's Self-Paced Weight Management kit. This education resource provides practical information on weight management with a central focus on attitudes about food and fitness to create a healthier lifestyle. Each Self-Paced Weight Management Kit contains: eating tips, food and activity logs, fast food guide, and much more valuable information to help you lose weight and learn how to keep if off. (Kits are available at all medical office pharmacies; no prescription required.)	$15 flat fee
Parenting – how to talk so kids will listen Based on the book, How to Talk So Kids Will Listen So Kids Will Talk, this program will help you communicate more effectively with your children by increasing your communication and behavior-management skills. You'll learn about: helping children deal with their feelings, engaging cooperation, alternatives to punishment, using praise effectively, freeing children from playing roles.	$40 one parent (one text and one workbook included) $50 two parents (two texts and two workbooks included)
Weight Management – Slim For Life Kaiser Permanente is partnering with the American Heart Association to offer the "Slim for Life" program. Participants will learn how to reduce excess weight and keep if off through a proper, nutritious diet. "Slim for Life," is a realistic weight-loss program that uses a behavior modification approach to change your eating habits. A registered dietician teaches this 10-week class, so you can learn about hearty healthy foods that are good for you and your body.	$50 flat fee for 10 weeks

To find out specific dates and locations for classes call 800/870-5711 or for the hearing impaired 913/642-3696.

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 AUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the authorization information shown in Section 3 to be sure which services require authorization and identify which surgeries require authorization.	IMPORTANT

Benefit Description	You pay
Surgical procedures	
• 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 -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Voluntary sterilization (tubal ligation and vasectomy) • Insertion of internal prosthetic devices. See Section 5(a) – orthopedic braces and prosthetic devices for device coverage information. • Treatment of burns	$10 per visit in a physicians office Nothing in a hospital

Surgical procedures	You pay
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot*	*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: cleft lip; cleft palate; webbed fingers; and webbed toes • 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 can choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per visit in a physicians office Nothing in a hospital
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in a bodily form, except repair of accidental injury* • *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 • Non-dental surgical and hospitalization procedures for congenital defects, such as correction of cleft lip, cleft palate, or severe functional malocclusion • Medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts • 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 visit in a physicians office Nothing in a hospital
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Other procedures that involve the teeth or intra-oral areas surrounding the teeth, including shortening of the mandible or maxillae for cosmetic purposes* • *Correction of malocclusion*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/Lung • Kidney • Pancreas • Kidney/Pancreas • Liver and lung (single and double) • Allogeneic (donor) bone marrow transplants • Autologous bone marrow (autologous stem cell and peripheral stem cell support) for the following conditions: •• Acute lymphocytic or non-lymphocytic leukemia •• Advanced Hodgkin's lymphoma •• Advanced neurolastoma •• Breast cancer •• Multiple myeloma •• Epithelial ovarian cancer •• Testicular •• Mediastinal •• Retroperitoneal and ovarian germ cell tumors After the referral to a transplant facility, the following applies: • If our Medical Group or the referral facility decides you do not satisfy criteria for a transplant, we only pay for covered services you receive before that decision is made • We, our Medical Group, and providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor • We cover reasonable medical and hospital expenses as long as the expenses are directly related to a covered transplant of the donor or an individual identified by Medical Group as a potential donor, even if a Member • Unless otherwise authorized by our Medical Group, we provide transplants only at network Centers of Excellence	$10 per visit in a physicians office Nothing in a hospital

Not covered: • *Bone marrow transplants associated with high dose chemotherapy for the treatment of solid tissue tumors, except for germ cell tumors, neuroblastoma in children, and breast cancer* • *Implants of non-human or artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**You pay**
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center	Nothing
Professional services provided in a provider office	$10 per office visit

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

	IMPORTANT	**Here are some important things to remember 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: • Ward, semiprivate, intensive care, or cardiac care accommodations • General nursing care • Meals and special diets Note: A Plan physician, if it is medically necessary, may prescribe private accommodations or private duty nursing care. If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing

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 • 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: calendar year coinsurance applies) 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.	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools, and residential treatment centers* • *Personal comfort items, such as telephone, television, barber services, guest meals, and beds* • *Private nursing care* • *Inpatient dental procedures*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay
• 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 • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$50 for each outpatient surgery
Not covered: • *Blood and blood derivatives not replaced by the member*	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Up to 100 days per calendar year when: • Full-time skilled nursing care is necessary • Confinement in a skilled nursing facility is medically appropriate Services include: • Bed, board, and general nursing • Prescribed drugs and their administration • Biologicals • Supplies • Durable medical equipment ordinarily provided or arranged for use while in the facility	Nothing
Not covered: • *Custodial care* • *Care in an intermediate care facility*	*All charges*

Hospice care	You pay
Supportive and palliative care for a terminally ill member: • You must reside in the service area • Services are provided in the home • Services are provided in a Plan approved hospice facility Note: 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
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*
Ambulance	
Professional ambulance service to the nearest hospital equipped to handle your medical condition when authorized by Plan physician	$50 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 the local emergency system (e.g., the local 911 telephone system). When the operator answers, stay on the phone and answer all questions.

Emergencies within our service area:

Emergency care is provided at Plan hospitals 24 hours a day, seven days a week. If you have a medical emergency, go to the closest Plan hospital. If you reasonably believe you have a medical emergency condition and you cannot safely go to a Plan hospital, call 911 or go to the nearest hospital. If an ambulance comes, tell the paramedics that the person who needs help is a Kaiser Permanente member.

If you are admitted to a non-Plan facility, call the Patient Transfer Coordinator at 913/385-1155. From all other areas dial 800/870-5711 and ask for the Patient Transfer Coordinator. You must notify the Plan as soon as is reasonably possible. If you are hospitalized in a non-Plan facility and Plan physicians believe your care can be better provided in a Plan facility, we will transfer you when medically feasible.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan facility would result in death, disability, or significant jeopardy to your condition.

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified as soon as is reasonably possible. If a Plan physician believes care can be better provided in a Plan hospital, we will transfer you when medically feasible.

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 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 the Member Services Department from Kansas at 913/642-2662, or from other areas call 800/726-5247 or the TTY number at 913/642-3696.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a physician's office • Emergency care at an urgent care center	$10 per visit
• Emergency care as an outpatient at a hospital, including physicians' services Note: We waive the copay if you are admitted to the hospital.	$50 per visit
Not covered: • *Elective care or non-emergency care*	*All charges*
Emergency outside our service area	
• Emergency care at a physician's office • Emergency care at an urgent care center	Nothing
• Emergency care as an outpatient at a hospital, including physicians' services	$50 per visit
• In a Kaiser Foundation hospital in another Kaiser Foundation Health Plan service area Note: See the Travel Benefit for coverage of continuing or follow-up care.	The amount you would be charged if you were a member in that service area
Not covered: • *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*	*All charges*
Ambulance	
• Professional ambulance services to the nearest hospital equipped to handle your medical condition where authorized by a Plan physician • We will authorize air ambulance if ground transportation is not medically appropriate	$50 per transport
Not covered: • *Transports we determine are not medically necessary*	*All charges*

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.
- **YOU MUST GET PREAUTHORIZATION FOR SOME OF THESE SERVICES**. See the instructions after the benefits description below.

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 no greater than for other illnesses or conditions

Diagnosis and treatment of psychiatric conditions, mental illness and mental disorders. Services include: • Diagnostic evaluation • Treatment (including individual and group therapy visits) • Crisis intervention and stabilization for acute episodes • Psychological testing necessary to determine the appropriate treatment • 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) • Rehabilitation 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 an outpatient mental health or substance abuse provider without a referral from your primary care physician. However, before you see a mental health provider you must obtain authorization of the visit from American Psych Systems at 888/970-1200. They can be reached for routine referrals between 8:00 a.m. and 6 p.m. EST Monday through Friday, or for emergency services 24 hours a day. Your mental health provider will obtain subsequent authorizations for treatment.	$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 substance abuse care • Inpatient detoxification Note: All inpatient treatment must be authorized through American Psych Systems at 888/970-1200.	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 Plan 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 physician, referral physician, or oral surgeon must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy. You may obtain maintenance medications through the mail.
- **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. The formulary includes prescription drugs that have been approved by our Pharmacy and Therapeutics Committee. This committee selects prescription drugs for the formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets quarterly to consider adding and removing prescription drugs on the drug formulary. If you like information about whether a specific drug is included in our drug formulary, please call Member Services at 913/642/2662.

  If your physician specifically prescribes a non-formulary drug because it is medically necessary, you will receive the non-formulary drug at the Plan copayment. If you request the non-formulary drug when your physician has prescribed a substitution, we will not provide the non-formulary drug. However, you may purchase the non-formulary drug from a Plan pharmacy at our allowance.
- **These are our dispensing limitations.** Generic and brand name prescriptions are available in a 30-day supply. Mail order prescriptions are available for two copayments in a 60-day supply, subject to a $2.00 delivery charge. Some prescriptions, such as controlled substances, are not available by mail order. If you have questions about a specific mail-order drug, please contact your Plan pharmacy.
- **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 • Insulin (per vial) • Glucose test strips	$5 per prescription or refill
• Disposable needles and syringes needed for injecting covered prescribed drugs • Any equipment necessary to use a prescribed drug • Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU) • Immunosuppressant drugs required after a covered transplant • Intravenous fluids and medications for home use • Enteral elemental dietary formulas when used as primary therapy for regional enteritis • Chemotherapy drugs • Oral contraceptives and diaphragms	Nothing
Implanted time-release drugs (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.	One-time payment of $5 times the expected number of months the drug will be effective, not to exceed $200
Implanted contraceptives (Depo-Provera)	One-time payment of $5 times the expected number of months the drug will be effective, not to exceed $200
• Drugs to treat sexual dysfunction Note: These drugs have dispensing limitations. Contact the Plan for details.	50% of our allowance

Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Drugs related to non-covered services* • *Drugs related to infertility services* • *Smoking cessation drugs, except for nicotine gum* • *Vitamins and nutritional supplements that can be purchased without a prescription* • *Drugs available without a prescription or for which there is a non-prescription equivalent available*	*All charges*

Section 5 (g). Special features

Feature	Description
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. This amount will be deducted from the payment we make to you. • Your benefit is limited to $1200 each calendar year. • For more information about this benefit call 1-800-390-3509. • File claim as shown on page 47. *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.)*
Flexible benefits options	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. • Alternative benefits are subject to our ongoing review. • 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.

24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call from Kansas at 913/385-1155, or from other areas call 800/870-5711 or for the hearing impaired call 800/324-8007 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Centers of excellence for transplants	The Centers of Excellence program began in Fall 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted "Centers of Excellence" for certain specialized medical procedures. We have developed a national contract network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.
Services from other Kaiser Permanente Plans	When you are visiting in 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 charges imposed by the Plan you are visiting. If the Plan you are visiting has a benefit that is different 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 available 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 the Plan in which you are enrolled. If you are seeking routine, non-emergent, or non-urgent services, you should call the Kaiser Permanente Member 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 the service area of this Plan. 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 plan to travel to an area with another Kaiser Permanente plan, and wish to obtain more information about the benefits available to you from the Kaiser Permanente plan, please call Member Services at 800/726-5247.

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.	IMPORTANT

Accidental injury benefit

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.	You pay 50% of the first $1,000 in charges per injury and all charges thereafter

Dental Benefits

Service	You pay
General dentist (you pay restorative services)	
Amalgam (fillings silver, plastic or composite)	$34 – $75
Inlay/Onlay	$205 – $340
Crowns (Stainless steel, cast or porcelain/metal)	$130 – $450
Periodontic services	
Root planning (per quadrant)	$115
Occlusal adjustment	$50 – $230
Endodontic services	
Root canals	$240 – $420
Oral surgery	
Simple extraction	$45
Extractions (each additional tooth)	$40
Surgical removal of erupted tooth	$85
Prosthetic services	
Dentures (complete upper or lower)	$460 – $495
Partial dentures	$405 – $505
Denture relines	$135 – $170

Orthodontic services	
Standard fully banded case (available to members age 19 and under)	$2,750

Oral exam, x-rays, prophylaxis (cleaning of teeth) every six months, fluoride treatment, and oral hygiene instruction are covered with a $5 copayment per member per visit.

This list of services and copayment ranges is a general summary and may vary depending on specific services required. These procedures are only available at participating general dental offices. Should your general dentist refer you to an affiliated specialist, the charges may be higher. If you have questions regarding specific covered services and corresponding copayments, please contact a Customer Service Representative at (800) 445-9090.

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.

If you are enrolled in this Plan through the FEHBP, have Medicare Part A coverage and have purchased Part B coverage, you also may enroll in the Kaiser Permanente Senior Advantage program.

The Senior Advantage Program Plan provides all Medicare covered Part A and Part B benefits to the Medicare beneficiary, as well as some benefits not covered by Medicare. It is an arrangement between Medicare and this Plan in which Medicare pays a specific amount to this Plan for each Medicare beneficiary who enrolls in the Plan.

Like your FEHBP enrollment in this Plan, you are required to obtain your services from this Plan's physicians and providers, except for emergencies and out-of-area urgent care. The rules regarding enrollment in Kaiser Permanente Senior Advantage are fully explained in the Certificate of Coverage for Senior Advantage Federal members. For a copy of these rules, please contact Member Services at 913/642-2662 or 800/726-5247.

Following your enrollment in Kaiser Permanente Senior Advantage, you will be entitled to receive an enhanced benefits package that combines your FEHBP coverage with your Kaiser Permanente Senior Advantage Benefits.

If you choose to enroll in Senior Advantage, you will be responsible for paying the Part B premium. You must make an affirmative enrollment in Senior Advantage. Refer to the Certificate of Coverage for Senior Advantage Federal members for complete enrollment and disenrollment rules. You will also continue to pay the employee share of the FEHBP premium.

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)); for travel benefit services (see section 5(g)); and for 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 affiliated 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 800/726-5247.

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:

Kaiser Permanente
Member Claims
P.O. Box 378044
Denver, Colorado 80237

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.

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 preauthorization:

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: Kaiser Foundation Health Plan of Kansas City, Attn: Member Services, 10561 Barkley, Suite 200, Overland Park, KS 66212; 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 913/642-2662 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/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 payer 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. Your primary care physician must continue to authorize 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. 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 913/967-4600. Your Kaiser Permanente Senior Advantage-FEHBP benefits are:

- Medical office visits: $0
- Preventive office visits: $0
- Urgent care: $0
- Prescription benefits: $3 for a 60-day supply
- Vision: $0 for lenses, $50 credit for frames
- Hearing aid: $800 credit for hearing aid

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.

Copayment

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

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.

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 the Kansas City, Inc.

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 at 913/642-2662 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.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2001. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2000 open season, November 13, 2000, through December 11, 2000. Your coverage will begin January 1, 2001. DoD has set up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 2000 and 2001 open seasons. Your coverage will begin January 1 of the year following the open season during which you enrolled.

If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a website devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations, and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2001 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

TCC eligibility

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your Self and Family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration P

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 Kansas City, Inc. – 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	13
Services provided by a hospital:		
• Inpatient	Nothing	29
• Outpatient	$50 for each outpatient surgery	31
Emergency benefits:		
• In-area	$50 per visit	34
• Out-of-area	$50 per visit	34
Mental health and substance abuse treatment:	Regular cost sharing	35
Prescription drugs	$5 per prescription	38
Dental Care	Various copays based on procedure rendered	43
Vision Care	Refractions; $10 per office visit	17
Special features: Travel benefit; Flexible benefits options; 24 hour nurse line; Centers of excellence for transplants; Services from other Kaiser Permanente Plans		41
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	11

2001 Rate Information for
Kaiser Foundation Health Plan of Kansas City, Inc.

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	HA1	$63.62	$21.21	$137.85	$45.95	$75.29	$9.54
Self and Family	HA2	$164.15	$54.71	$355.65	$118.55	$194.24	$24.62