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Kaiser Foundation Health Plan of Georgia, Inc.

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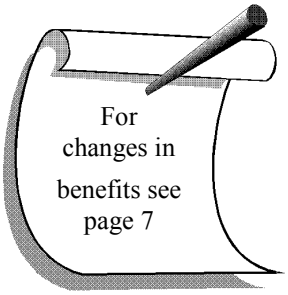
2001

A Health Maintenance Organization



Serving: *Atlanta, Georgia metropolitan area*

Enrollment in this Plan is limited; see page 5 for requirements.

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

Enrollment codes for this Plan:

F81 Self Only
F82 Self and Family

Authorized for distribution by the:

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 73-321

Table of Contents

Introduction

Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, Georgia 30305-1736

This brochure describes the benefits of Kaiser Foundation Health Plan of Georgia, Inc. under our contract (CS 2163) 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 Georgia, 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, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

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

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

How we pay providers

We contract with the Southeast Permanente Medical Group, Inc. and hospitals to provide the benefits in this brochure. Your medical group physicians are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee-for-service and incentive payments. Other Plan providers accept a negotiated payment from us. You will only be responsible for your copayments or coinsurance. If you would like further information about the way Kaiser Permanente physicians are paid to provide or arrange medical and hospital care for you, please call us at 404/261-2590.

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.

- Kaiser Foundation Health Plan of Georgia, Inc., a Georgia not-for-profit corporation, is a wholly owned subsidiary of Kaiser Foundation Health Plan, Inc. We are a federally qualified health maintenance 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.

- In October 1995, Kaiser Permanente began operations in the State of Georgia. Kaiser Permanente is one of the largest group practice health plans in Georgia. We provide health care to more than 258,000 members in the greater Atlanta area.

- In 2000, we received a three-year, full accreditation now known as "Excellent Accreditation" from the National Committee for Quality Assurance (NCQA).

- All Kaiser Permanente affiliated hospitals are accredited by JCAHO, the commission that sets nationally recognized health care standards for hospitals and other health care organizations.

- Kaiser Permanente reviews the credentials – including licensing, education, training, experience, health status, judgement, and office conditions – of physicians before they are selected to participate in our medical care program, and we review them on an ongoing basis.

- We credential Plan providers in accord with national standards.

- Plan physicians are members of American Specialty Boards or are Board eligible.

If you want more information about us, call 404/365-0966, or write to: Kaiser Permanente, Member Services Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736.

You may also contact us by visiting our website at www.kp.org/ga.

Service Area

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

Bartow, Barrow, Butts, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale, Spalding, and Walton County

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 42; and for emergency care obtained from any non-Plan provider, as described on page 33. We will not pay for any other health care services.

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

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from Plan providers will be the same with regard to coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Your mental health and substance abuse benefits have been changed to reflect this requirement.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling our Member Service Department at 404/261-2590. 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 6.1% for Self Only or 6.2% for Self and Family.
- Scoliosis braces, formerly provided at a $200 copayment, are provided at a 20% copayment like other external prosthetic and orthotic devices.
- We cover extraction of teeth prior to radiation therapy treatment at a $10 copayment. Previously this benefit was not covered.
- We cover allergy serum at no charge. Previously this benefit was provided at a copayment of $50 per 6 month supply.

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 our Member Service Department at 404/261-2590 (locally), 800/611-1811 (long distance) or 800/255-0056 (TTY number).

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. We contract with the Southeast Permanente Medical Group, Inc. (Plan physicians) an independent multi-specialty group of physicians to provide or arrange all necessary physician care. Plan physicians, nurse practitioners, physician assistants, and other skilled medical personnel working as medical teams provide your health care services. Specialists consult with these medical teams in determining your treatment. Plan physicians refer patients to community specialists when necessary. We also contract with American Dental Plan (ADP) to provide or arrange covered dental care.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website at www.kp.org/ga.

•Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. Other services, such as physical therapy, laboratory and X-ray, are available at Plan facilities and other designated locations. Hospital care is provided at local community hospitals. We list these 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. Our website has information about our providers.

•Primary care

We require you to choose a primary care physician when you enroll. Every member of your family should have his or her own primary care physician. If you do not select a primary care physician upon enrollment,

we will assist you by identifying a physician in a medical center near your home and including you in that physician's panel of patients. That physician will be listed in our records as your primary care physician until you make a selection and inform us of your decision.

When choosing your primary care physician, keep in mind that your choice will determine where you will receive specialty care. Your primary care physician has an established relationship with a specific group of specialty care physicians with whom he or she works and trusts. By referring only to a select group of specialists, your primary care physician is better able to ensure that you receive high-quality care.

You may select your primary care physician from the medical group or affiliated community physicians. The medical group physicians provide care at Kaiser Permanente medical centers in our service area. An affiliated community physician provides care in his or her own medical office. Your primary care physician can be a family practitioner, internist, or pediatrician. Adults should select an internal medicine or family practice physician. Parents can choose a pediatric or family practice physician for their children, or a family practice physician can be selected for the entire family. To learn how to choose or change a primary care physician, please call our Member Services Department at 404/261-2590 (locally), 800/ 611-1811 (long distance) or 800/255-0056 (TTY number).

If you wish to be treated by a physician at a Kaiser Permanente medical center or by another affiliated community physician, you will need to select that individual as your new primary care physician before scheduling treatment.

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. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see obstetricians/gynecologists, dermatologists, and ophthalmologists without a referral.

Here are other things you should know about specialty care:

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

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

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

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

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

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

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

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Member Services Department immediately at 404/261-2590. 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 pre-authorization. Your physician must obtain pre-authorization for the following services:

- All inpatient hospital care services
- Extended care/ skilled nursing facility services
- Inpatient mental health or substance abuse services
- Inpatient rehabilitation therapy services or programs
- Organ and tissue transplants
- Outpatient procedures and services:
  - Knee arthroscopy
  - Infertility procedures
  - Carpal tunnel surgery
  - Repair of nasal septum
  - Speech therapy
  - Comprehensive outpatient rehabilitation facility services
  - Home Health Care
  - Hospice care
  - Durable Medical Equipment
  - Orthopedic and Prosthetic Devices
  - Circumcision (Pediatric and adult)
  - Plastic or reconstructive Surgery
  - Varicose Vein Stripping
  - Blepharoplasty
  - Spinal Cord Stimulation
  - HBO Treatment
  - Pain management
  - Biofeedback
  - Intrathecal and epidural infusion pumps
  - Any request for non-Plan provider
- Other services:
  - Referrals to specific specialists and recommendations for follow up care

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 certain services you receive.

  Example: In our Plan, you pay 50% of our allowance for infertility services and 20% of our allowance for durable medical equipment.

- **Fees when you fail to make your copayment or coinsurance**

  If you do not pay your copayment or coinsurance at the time you receive services, we will bill you. You will be required to pay a $15 charge for each bill sent for unpaid services.

Your out-of-pocket maximum for copayments and coinsurance

After your copayments and coinsurance total $2,000 per person or $5,000 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 as described in this brochure:

- prescription drugs
- durable medical equipment
- external prosthetic and orthotic devices
- the $25 charge for follow-up or continuing care
- chiropractic services
- dental services
- any non-FEHB benefits

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

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 61 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 404/261-2590 or at our website at www.kp.org/ga.

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. • YOU MUST GET PRE-AUTHORIZATION FOR SOME MEDICAL PROCEDURES. Please refer to the pre-authorization shown in Section 3 to be sure which services and supplies require pre-authorization.	IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	**You pay**
Professional services of physicians and other health care professionals • In a physician's office • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion • In a Plan After Hours Care Center	$10 per office visit
• In any other urgent care center designated by the Plan	$20 per visit
• In a skilled nursing facility • During a hospital stay	Nothing

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

Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Participating in employee programs* • *Insurance or licensing* • *Court order required for parole or probation* • *Attending schools* • *Travel*	*All charges*
Preventive care, children	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics • Well-child preventive care visits (up to 2 years of age)	Nothing
• Examinations, such as: •• Eye exams to determine the need for vision correction •• Ear exams to determine the need for hearing correction •• Examinations done on the day of immunizations • Well-child care charges for routine examinations, and care (over age 2)	$10 per office visit
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Participating in employee programs* • *Insurance or licensing* • *Court order required for parole or probation* • *Attending schools or camp* • *Travel*	*All charges*
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery.	Nothing

• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your Plan 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.	
Not covered: • *Routine sonograms to determine fetal age, size, or sex*	*All charges*
Family planning	**You pay**
Family planning services, including: • Voluntary sterilization • Information on birth control Note: We cover surgically implanted contraceptives, injectable contraceptive drugs and intrauterine devices (IUDs) under your prescription drug benefit.	$10 per office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	
Diagnosis and treatment of involuntary infertility • Artificial insemination: •• intravaginal insemination (IVI) •• intracervical insemination (ICI) •• intrauterine insemination (IUI) • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefits.	50% of our allowance

Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization* •• *embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Semen or eggs, and services and supplies related to their procurement and storage* • *Cost of donor sperm* *Note: Infertility services are not available when either member of the family has been voluntarily surgically sterilized.*	*All charges*
Allergy care	**You pay**
Testing and treatment	$10 per office visit
Allergy injections	$5 per office visit
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: We limit high dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page xx. • Respiratory and inhalation therapy • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy Note: We cover growth hormone therapy (GHT) under the prescription drug benefit. • Dialysis Note: We waive office visit charges if you enroll in Medicare Part B and assign your Medicare benefits to us.	$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 by occupational therapists to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life Note: If you have not received 20 or more outpatient visits within the two-month period that started with your first visit to a therapist, we may continue your therapy for up to 20 outpatient visits per therapy per condition. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 12 weeks or 36 visits	$10 per office visit
• Comprehensive outpatient rehabilitation facility services are provided up to two months per condition. Outpatient rehabilitation, including diagnostic and restorative services, providing a program of physical, speech, occupational, respiratory therapy, social and psychological services, and other items and services that are medically necessary for rehabilitation. The two month limit applies to all inpatient and outpatient comprehensive rehabilitation services you may receive for the same condition.	$10 per office visit (nothing for inpatient service)
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Cognitive rehabilitation programs* • *Vocational rehabilitation programs* • *Therapies done primarily for education purposes*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Hearing test to determine the need for hearing correction • Hearing testing for children through age 17 (see Preventive care, children)	$10 per office visit
Not covered: • *All other hearing tests* • *Hearing aids, tests to determine their effectiveness, and examinations for them*	*All charges*

Vision services (testing, treatment, and supplies)	You pay
• Annual eye refractions for eyeglasses (to provide written lens prescription)	$15 per office visit
• Diagnosis and treatment of diseases of the eye	$10 per office visit
Not covered: • *Corrective eyeglasses and frames or contact lenses (including the examination and fitting of contact lenses)* • *Refractions for contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *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	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$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	
External prosthetic and orthotic devices, such as: • Artificial limbs and eyes; stump hose • Braces • Therapeutic shoes required for conditions associated with diabetes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Scoliosis braces • Lenses following cataract removal • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	20% of our allowance

• Internal prosthetic devices, such as artificial joints, pacemakers, intraocula lens following cataract removal, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device.	Nothing
Not covered: • *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* • *Devices, equipment, supplies, and prosthetics related to the treatment of sexual dysfunction* • *External and internally implanted hearing aids* • *Experimental or research equipment*	*All charges*
Durable medical equipment (DME)	**You pay**
Durable medical equipment (DME) is equipment and supplies that are intended for repeated use, medically necessary, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, designed for prolonged use, appropriate for use in the home, and serving a specific therapeutic purpose in the treatment of an illness or injury. Covered items include: • Hospital beds • Wheelchairs, except motorized • Crutches • Walkers • Infant apnea monitors • Oxygen-dispensing equipment • Oxygen Note: We decide whether to rent or purchase the equipment, and we select the vendor. We will repair the equipment without charge, unless the repair is due to loss or misuse.	20% of our allowance

Not covered: • *Motorized wheel chairs* • *Comfort, convenience, or luxury equipment or features* • *Exercise or hygiene equipment* • *Non-medical items such as sauna baths or elevators* • *Modifications to your home or car* • *Devices for testing blood or other body substances* • *Electronic monitors of bodily functions, except apnea monitors and blood glucose monitors* • *Disposable supplies* • *Replacement of lost equipment* • *Repair, adjustments, or replacements necessitated by misuse* • *More than one piece of durable medical equipment serving essentially the same function, except for replacements other than those necessitated by misuse or loss* • *Spare or alternate use equipment* • *Devices, equipment, supplies, and prosthetics for the treatment of sexual dysfunction disorders* • *External and internally implanted hearing aids* • *Experimental or research equipment*	*All charges*
Home health services	**You pay**
If you are homebound and reside in the service area: • You may receive home health services of nurses and health aides, physical or occupational therapists, and speech and language pathologists • Services include oxygen therapy, intravenous therapy, and medications Note: Your Plan physician will periodically review the program for continuing appropriateness and need.	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* • *Custodial care* • *Care that the Medical Director of the Medical Group or his/her designee determines may be appropriately provided in a Plan facility, skilled nursing facility, or other facility we designate and we provide or offer to provide that care in one of these facilities* • *Services outside our service area*	*All charges*
Alternative treatments	**You pay**
Chiropractic services up to 30 visits per calendar year, for the following services: • Evaluation and management • Routine chiropractic X-rays provided in the chiropractor's office (not to exceed 4 views) • Chiropractic adjustments • Appropriate therapies (e.g. hot and cold packs) not to exceed 2 per visits Note: You may see a chiropractor without referral from your Plan physician. Services must be provided from our list of Participating Chiropractors. Please contact us to get the list.	$10 per office visit

Not covered: • *Vitamins and supplements* • *Vax-D* • *Structural supports* • *Massage therapies* • *Maintenance/preventative care* • *Acupuncture therapy* • *Physical, speech, and occupational therapy provided by a chiropractor* • *Neurological testing, unless authorized by your primary care physician* • *Laboratory and pathology services, unless authorized by your primary care physician*	*All charges*
Educational classes and programs	**You pay**
Training in self-care and preventive care	$10 per office visit
Health education publications and education about how to use our services and supplies	Nothing
General health education not addressed to a specific condition, as well as Lamaze classes, weight control classes, and stop-smoking classes	Charges vary ($0 to $50)
Note: This information is a summary of services available. Please call us at 404/261-2590 for availability and location of these classes.	

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 do not have a 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 PRE-AUTHORIZATION FOR SOME SURGICAL PROCEDURES. Please refer to the pre-authorization shown in Section 3 to be sure which services and surgeries require pre-authorization. • 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.).	IMPORTANT

Benefit Description	You pay
Surgical procedures	**You pay**
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- 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 • Insertion of internal prostethic devices. See Section 5(a) – Orthopedic braces and prosthetic devices for coverage information	$10 per office visit for outpatient services Nothing for inpatient services
• Voluntary sterilization (tubal ligation and vasectomy) • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs). Note: Devices are covered under Section 5(a) • Treatment of burns	$10 per office visit for outpatient services Nothing for inpatient services

Not covered: • *Reversal of voluntary sterilization* • *Routine foot care; see Foot care*	*All charges*
Reconstructive surgery	**You pay**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance; and •• the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities, cleft lip, cleft palate, birthmarks, web fingers, and toes. • Treatment of port wine stains on the face of members 18 years or younger • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; and •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per office visit for outpatient services Nothing for inpatient services
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in 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 • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	$10 per office visit for outpatient services Nothing for inpatient services
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Shortening of the mandible or maxillae for cosmetic purposes and correction of malocclusion*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols Note: We cover related medical and hospital expenses of the donor when we cover your transplant.	$10 per office visit for outpatient services Nothing for inpatient services
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of non-human or artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

Here are some important things to 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 do not have a 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).
- YOU MUST GET PRE-AUTHORIZATION FOR ALL NON-EMERGENCY INPATIENT HOSPITAL CARE SERVICES. Please refer to the pre-authorization shown in Section 3 to see which services require pre-authorization.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	**You pay**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: Your physician may prescribe accommodations or private duty nursing care if is medically necessary. 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. The collection and storage of autologous blood for elective surgery is covered when authorized by a Plan physician • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The conditions for which we will provide hospitalization include hemophilia and heart disease. The need for anesthesia, by itself, is not such a condition.	Nothing
Not covered: • *Personal comfort items, such as telephone, television, barber services, guest meals, and beds* • *Private nursing care* • *Any inpatient dental procedures, except as shown above and in Section 5(h) under dental benefits*	*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	Nothing

Extended care benefits/skilled nursing care facility benefits	You pay
Up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate. We cover the following: • Physician and nursing services • Room and board • Medical social services • Blood, blood products, and their administration • Durable medical equipment ordinarily furnished by a skilled nursing facility, including oxygen-dispensing equipment and oxygen • Respiratory therapy • Biological supplies • Medical supplies	Nothing
Not covered: • *Custodial care in an intermediate care facility* • *Custodial care*	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member: • You must reside in the service area • Services are provided in the home • Services are provided in a Plan approved hospice facility Services include inpatient care, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less. Note: Hospice is a program for caring for the terminally ill that emphasizes supportive services, such as home care and pain control, rather than curative care of the terminal illness. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, physician services, and short-term inpatient care for pain control and acute and chronic symptom management. We also provide counseling and bereavement services for the individual and family members, and therapy for purposes of symptom control to enable the person to continue life with as little disruption as possible. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.	Nothing

Not covered: • *Independent nursing* • *Homemaker services*	*All charges*
Ambulance	
• Local professional ambulance service when ordered or authorized by a Plan physician	$50 per trip
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. • We do not have a 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 a medical emergency:

If you have a medical emergency, dial 911 or go to the nearest emergency room.

Emergencies within our service area:

Emergency care is provided at Plan Hospitals 24 hours a day, seven day a week. The location and phone number of your nearest Kaiser Permanente hospital may be found in your FEHBP Facility Guide.

If you think you have a medical emergency condition and you cannot safely go to a Plan Hospital, call 911 or go to the nearest hospital. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the plan within 48 hours, unless it was not reasonably possible to do so.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in non-Plan facilities and Plan physicians believe care can be better provided in a Plan hospital, we will transfer you when medically feasible, with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider 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 within 48 hours or on the first working day following your admission, unless it was not reasonable possible to notify the Plan within that time. If a Plan physician believes care can be better provided in a Plan hospital, then we will transfer you when medically feasible, with any ambulance charges covered in full.

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 will be 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 in the Atlanta area at 404/261-2590, or from other areas at 800/611-1811.

Benefit Description	You pay
Emergency within our service area	
Emergency care as an outpatient or inpatient at a hospital, including physicians' services • Emergency care at an urgent care center • Emergency care in a hospital emergency room Note: Your copayment is waived if you are admitted to a hospital.	$50 per visit
Not covered: • *Elective care* • *Non-emergency care*	*All charges*
Emergency outside our service area	
Emergency care as an outpatient or inpatient at a hospital, including physicians' services • Emergency care at a physician's office • Emergency care at an urgent care center • Emergency care in a hospital emergency room	$50 per visit
• Emergency care 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 service when medically appropriate	$50 per trip
Not covered: • *Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation, even if it is the only way to travel to a facility* • *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.	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, mental illness, or disorders of children, adolescents, and adults. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Psychological testing to determine the appropriate psychiatric treatment • Outpatient psychiatric treatment (including individual and group therapy visits) • Medication evaluation and management Diagnosis and treatment of alcoholism and drug abuse. Services include: • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) • Rehabilitative care Note: You may see an outpatient mental health or substance abuse provider without a referral from your primary care physician. See Section 3, *How you get care* for information about services requiring our prior approval. 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.	$10 per office visit
• Inpatient mental health and substance abuse care • Hospital alternative services, such as partial hospitalization and intensive outpatient psychiatric treatment programs Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan physician.	Nothing
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Continued services if you do not substantially follow your treatment plan* • *Services we have not approved* • *Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* • *Services that are custodial in nature* • *Services rendered or billed by a school or a member of its staff* • *Services provided under a federal, state, or local government program* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms*	*All charges*

Special transitional benefit

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

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

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

Benefit limitation

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

Section 5 (f). Prescription drug benefits

	I M P O R T A N T	**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 clinically appropriate to treat your condition. • 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.	**I M P O R T A N T**	

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

- **Who can write your prescription.** A Plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy or a Plan participating community pharmacy. It may be possible for you to receive refills by mail at no extra charge. Delivery may be made available at an additional charge. Ask for details at a Plan Pharmacy. We pay a higher level of benefits when you use a network pharmacy.
- **We use a formulary.** We use a formulary, which is a listing of preferred pharmaceutical substances and formulas that our physicians and pharmacists consider to be the most safe, useful and cost-effective ones available. 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. Coverage for prescription drugs is limited to those drugs that are included on the Kaiser Permanente formulary.

  If you request a non-formulary drug – when your physician feels there is an acceptable formulary alternative – you will be responsible for the full cost of that drug.

  However, if your Plan physician believes that a non-formulary drug best treats your medical condition; a formulary drug has been ineffective in the treatment of your medical condition; or a formulary drug causes or is reasonably expected to cause a harmful reaction, then an exception process is available to your Plan physician. In that case, your standard prescription drug copayment would apply. This formulary exception process does not apply to your dentist. In order to be covered at your prescription drug copayment all prescriptions written by your dentist must be included on the Kaiser Permanente formulary.

  Unless otherwise specified by your Plan physician or dentist, generic drugs may be used to fill a prescription. If you request a brand name at Plan pharmacy or Plan participating community pharmacy, you pay the cost difference between the generic and brand name drugs, in addition to the applicable copayment.

  If you would like information about whether a particular drug is included in our drug formulary, or a list of our formulary drugs, please call our Member Services Department, at 404/261-2590.
- **These are the dispensing limitations.** Up to the lesser of a 30 day supply or the standard prescription amount of prescribed covered drugs and certain supplies. Drugs to treat sexual dysfunction have dispensing limitations. Contact us for details.
- **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	**You pay**
We cover the following medications and supplies: • Drugs for which a prescription is required by law • Diabetic supplies such as glucose test strips (Chemstrip®), Dextrostix®, sugar test tape, sugar test tablets, acetone test tablets • Inhalers • Spacer devices • Compounded dermatological preparation prepared by a pharmacist • Oral contraceptive drugs • Diaphragms • Growth hormone therapy (GHT) – for treatment of children with Turner's syndrome or classical growth hormone deficiency	$5 per prescription or refill if obtained at a Plan medical office pharmacy $11 per prescription or refill if obtained at a Plan participating community pharmacy
• Insulin	$5 per vial or refill if obtained at a Plan medical office pharmacy $11 per vial or refill if obtained at a Plan participating community pharmacy
• Disposable needles and syringes for the administration of covered medications • Intravenous fluids and medications for home use • Amino acid-modified products used to treat congenital errors of amino acid metabolism • Post-surgical immunosuppressant outpatient drugs required as a result of a covered transplant	Nothing
• Injectable contraceptives, including Norplant®	$180
• Depo Provera® • Other implanted time release drugs Note: We do not refund any portion of your copayment if you request removal of the implanted drug time-release medication before the end of its expected life.	$5 times the number of months the drug is expected to be effective, not to exceed $200
• Intrauterine devices	$50 per device
• Drugs for covered infertility treatments	50% of our allowance
• Drugs for sexual dysfunction Note: Drugs to treat sexual dysfunction have dispensing limitations.	50% of our allowance

Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins and nutritional supplements that can be purchased without a prescription* • *Nonprescription medicines or drugs for which there is a nonprescription equivalent available* • *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 infertility services* • *Contraceptive devices, except diaphragms and intrauterine devices* • *Smoking cessation drugs and medications, including nicotine patches* • *Drugs for non-covered services* • *Packaging of prescription medications is limited to Plan standard packaging; special packaging is not covered* • *Replacement of lost drugs and accessories* • *Infant formulas, except for amino acid-modified products noted above*	*All charges*

Section 5 (g). Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit • We review alternative benefits on an ongoing basis • By approving an alternative benefit, we cannot guarantee you will get it in the future • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 404/365-0966 (locally) or 800/611-1811 (long distance) and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	Our hearing and speech impaired TYY number is: 800/255-0056.
High risk pregnancies	**Comprehensive Maternity Program.** The goal is to significantly reduce the incident of pre-term deliveries and low birth weight babies by prompt interventions utilizing a multidisciplinary team approach. All women receiving prenatal care are assessed at the first provider visit (ideally during the first trimester) for factors associated with high-risk pregnancy. Risk scoring systems are based on a combination of past medical history (particularly reproductive history), current pregnancy events, personal habits during pregnancy, and demographic risks. Although risk scoring can identify some individuals at risk during pregnancy, no scoring system is so effective that those at risk may be safely ignored. Therefore, ongoing assessment must be done for all patients for symptoms and risk factors for pre-term birth. We are not able to implement any aspect of our maternity benefits on a "mandatory" basis. However, because copayments are waived for all prenatal and one postnatal visit, we have a 99% compliance with the recommended course of treatment.

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 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.
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 covered services for conditions diagnosed by a Kaiser Permanente health care provider or affiliated Plan provider that have been treated within the previous 90 days. Services include childhood immunizations, dialysis, or prescription drug monitoring • You pay $25 for each follow-up or continuing care office visit. We deduct this amount from the payment we make to you • We pay no more than $1200 each calendar year • For more information about this benefit call the Travel Benefit Information Line at 800/390-3509 • File claims as shown on page 48. *The following are not included in your travel benefits coverage:* • *Non-emergency hospitalization* • *Infertility treatments* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* • *Transplants* • *Prescription drugs (you may have prescriptions filled by mail through our prescription drug benefit)*

Services from other Kaiser Permanente plans	When you visit the service area of another Kaiser Permanente plan, you are entitled to receive virtually all the benefits described in this brochure at any Kaiser Permanente medical office or medical center. You will have to pay the copayments or other charges imposed by the Plan you are visiting. If the Plan you are visiting has a benefit that differs from the benefits of this Plan, you are not entitled to receive that benefit. Some services covered by this Plan, such as artificial reproductive services and the services of specialized rehabilitation facilities, will not be covered if you receive them in other Kaiser Permanente service areas. If a benefit is limited to a specific number of visits or days, you are entitled to receive only the number of visits or days covered by this Plan. If you are seeking routine, non-emergent, or non-urgent services, you should call the Kaiser Permanente Membership Services department in that service area and request an appointment. You may obtain routine follow-up or continuing care from these Plans, even when you have obtained the original services in our service area. If you require emergency services as the result of unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care. At the time you register for services, you will be asked to pay the charges required by the local Plan. If you wish to obtain more information about the benefits available to you from a Kaiser Permanente Plan in an area you visit, please call our Member Services Department at 404/261-2590 or 800/611-1811.

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 pay them only when we determine they are medically necessary. • Plan dentists must provide or arrange your care. Call Member Services for a list of participating dentists. • We have no calendar year deductible. • 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 except as 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

Dental Benefits

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	50% of the first $1,000 of our allowance; all charges thereafter

Other dental benefits	You pay
We cover non-surgical treatment of temporomandibular joint dysfunction (TMJ), including splints and appliances	50% of the first $1,000 of our allowance per calendar year; all charges thereafter
The following preventive dental services are covered when provided by a participating Plan dentist: • Oral examinations twice a year • Dental prophylaxis (cleaning) twice a year • Topical application of fluoride twice a year • Bitewing X-ray twice a year • Full mouth series X-rays once every three years Note: You receive a 10% discount from the Plan dentist's usual and customary fee schedule for all other dental care.	$14 per office visit

General anesthesia and associated hospital or ambulatory surgery facility charges in conjunction with dental care are covered for persons: • 7 years of age or younger • Who are developmentally disabled • Who are not able to have dental care under local anesthesia due to a neurological or medically compromising condition • Who have sustained extensive facial or dental trauma	Nothing
Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease	$10 per office visit
Not covered • *Other dental services not specifically shown as covered*	*All charges*

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

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

Expanded Dental Care

We are pleased to offer you and your family expanded dental coverage through the American Dental Plan.

CompDent Corporation offers you dental health maintenance organization benefits administered by American Dental Plan (ADP). You must choose a primary care dentist from the list of ADP dentists that is most convenient to you and your family. With ADP you have no claim forms to worry about. ADP provides a full range of services such as: preventive, restorative, endodontics, periodontics, prosthetics, and orthodontics. Under this program, you pay a copayment for all services which means a discount of approximately seventy-five percent (75%) off all covered services.

Monthly Premium*

Self Only	$ 11.00
Self & One Party	$ 20.10
Self & Two or More	$ 28.40

*These rates are effective January 1, 2001, through December 31, 2001

How To Enroll
Please read the enclosed flyer for a summary of the expanded dental plan. Use the postage paid card attached to the flyer to request enrollment information directly from CompDent. If you would like more information call 888/340-2282 and identify yourself as an Federal employee interested in the Kaiser Permanente/ADP Standard Option or High Option Dental Plan.

You must pay for the Standard Option or High Option by automatic monthly withdrawal from your checking, savings, or credit union account on an annual charge to your MasterCard or Visa.

Complementary and Alternative Medicine Program

As a Kaiser Permanente member, you can enjoy access to our Complementary and Alternative Medicine program, a unique program that offers discounted rates on a range of chiropractic, acupuncture, acupressure and massage therapy services. This program entitles you to receive your chiropractic care at a discounted rate after your covered 30 visits run out and other services not covered under your chiropractic benefit described in Section 5(a). Kaiser Permanente has created this program in partnership with Guardian Care Alliance. In order to receive the discount, you must choose from their designated list of providers. For information and provider availability, visit the Guardian Care Alliance website at www.guardiancarealliance.com.

SelfWise Program

As a Kaiser Permanente member, you are automatically enrolled in our *SelfWise* program. This program gives you easy access to products and services you can use to be a safer and healthier member of the community. Your membership to *SelfWise* entitles you to discounts on consumer health and safety merchandise, such as air purifiers, smoke detectors, carbon monoxide detectors and fire extinguishers. You will also have easy access to numerous health-related programs and classes at no cost or minimal cost to you; the absolute lowest rates for some of Atlanta's most popular health clubs; discounts on vacation getaways; and substantial discounts on many other services and merchandise related to improving your health.

Note: Keep in mind that these programs are discount programs. They are not a part of your FEHP benefits.

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical hospital, and drugs 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 404/261-2590.

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
Claims Administration
P.O. Box 190849
Atlanta, GA 31119-0849

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 pre-authorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Kaiser Foundation Health Plan of Georgia, Inc., Attention: Appeals Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta GA 30305-1736; 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, D.C. 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 404/261-2590 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or

- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

- **What is Medicare?**

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

- **The Original Medicare Plan**

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

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

(Primary payer chart begins on next page.)

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

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or …… b) The position is not excluded from FEHB…… Ask your employing office which of these applies to you.	……✓ ……	……..✓
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant…… 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 404/233-3700 (locally), 1-800-232-4404 (long distance) and 1-800-255-0056 (TTY line). Your Kaiser Permanente Senior Advantage-FEHBP benefits are:

- **Physician office visits**: $5 copayment for physician/specialist visit
- **Preventive care**: $5 copayment per visit for most adult preventive care services; no copayment for mammograms
- **Routine physicals and hearing exams**: $5 copayment per visit
- **Outpatient mental health and substance abuse**: $5 copayment per visit
- **Prescriptions**:
  - $3 for each generic/brand prescription obtained at a Plan medical office pharmacy
  - $9 for each generic/brand prescription obtained at a Plan participating community pharmacy
  - Mail-order service available through the Plan at an additional $2.50 postage/handling charge
- **Dialysis**: no copayments
- **Durable medical equipment**: no copayments
- **Orthopedic and prosthetic devices**: no copayments
- **Vision Services**:
  - $15 copayment for one routine eye exam each year
  - $40 frame allowance for one frame every two years; $60 allowance for cosmetic contact lenses in lieu of eyeglasses once every two years

You will also enjoy:

- Health/Wellness Education: $5 copayment for disease-specific health education classes (costs may vary for wellness classes)
- No deductibles and virtually no paperwork
- On-line access to health information and resources at our award-winning members only website
- Quarterly member communication in our "Senior Outlook" magazine
- Customized Senior Advantage new member orientation.

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 whom, 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 Georgia, 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 404/261-2590 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

• Penalties for Fraud

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

Index

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

Summary of benefits for Kaiser Foundation Health Plan of Georgia, 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	14
Services provided by a hospital:		29
• Inpatient	Nothing	
• Outpatient	Nothing	30
Emergency benefits:		34
• In-area	$50 per visit	
• Out-of-area	$50 per visit	34
Mental health and substance abuse treatment:	Regular cost sharing	35
Prescription drugs	$5 per prescription if obtained at a Plan medical office pharmacy; $11 per prescription if obtained at a Plan participating community pharmacy	38
Dental Care	Various copays based on procedure rendered	44
Vision Care	Refractions; $15 per office visit	20
Special features: Flexible benefits option; 24 hour nurse line; Services for deaf and hearing impaired; High risk pregnancies; Centers of excellence for transplants; Travel benefit; Services from other Kaiser Permanente Plans;		41
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after $2,000/Self Only or $5,000/Family enrollment per year Some costs do not count toward this protection	12

Notes

Notes

2001 Rate Information for
Kaiser Foundation Health Plan of Georgia, 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	F81	$72.57	$24.19	$157.24	$52.41	$85.87	$10.89
Self and Family	F82	$184.23	$61.41	$399.17	$133.05	$218.01	$27.63