Kaiser Foundation Health Plan, Inc. California Division

http://www.kaiserpermanente.org/california

KAISER PERMANENTE®

2002

A Health Maintenance Organization

Serving: *Northern/Southern California service areas*

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See pages 8 and 9 for requirements.

For changes in benefits, see page 10.

This Plan has excellent accreditation from the NCQA in the Northern California Service Area. See the 2002 Guide for more information on NCQA.

This Plan has commendable accreditation from the NCQA in the Southern California Service Area. See the 2002 Guide for more information on NCQA.

Enrollment codes for this Plan:

Northern California
591 Self Only
592 Self and Family

Southern California
621 Self Only
622 Self and Family

Authorized for distribution by the:

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

FEHB
Federal Employees Health Benefits Program

RI 73-003

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Introduction

Kaiser Foundation Health Plan, Inc., California Division
1950 Franklin Street, Oakland, CA 94612 (Northern California)
393 East Walnut Street, Pasadena, CA 91188 (Southern California)

This brochure describes the benefits of Kaiser Foundation Health Plan, Inc.—California Division under our contract (CS1044) 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 63. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" or "Plan" means Kaiser Foundation Health Plan, Inc.

- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.

- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation, 1900 E Street NW, Washington, DC 20415.

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 eceive, 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 our Member Service Call Center at 1-800-464-4000 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

We are a federally qualified health maintenance organization, and we have provided health care services to Californians since the 1950s. Kaiser Foundation Health Plan, Inc., is a California not-for-profit organization. This Plan is part of the Kaiser Permanente Medical Care Program, a group of not-for-profit organizations and contracting medical groups that serve over 8 million members nationwide. Our Medical Groups, The Permanente Medical Group, Inc., and the Southern California Permanente Medical Group, operate Plan medical offices throughout California.

If you want more information about us, call 1-800-464-4000, or write to 1950 Franklin Street, Oakland, California 94612, or 393 East Walnut Street, Pasadena, California 91188. You may visit our website at www.kaiserpermanente.org/california, which lists the specific types of information that we must make available to you.

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 is:

Northern California counties:	Alameda; Contra Costa; Marin; Sacramento; San Francisco; San Joaquin; San Mateo; Solano; Stanislaus.

Portions of the following counties, as indicated by the zip codes below, are also within the service area:

Amador County:	95640, 95669
El Dorado County:	95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
Fresno County:	93242, 93602, 93606-07, 93609, 93611–13, 93616, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–22, 93724–29, 93740–41, 93744–45, 93747, 93750, 93755, 93759–62, 93764–65, 93771–80, 93782, 93784, 93786, 93790–94, 93844, 93888
Kings County:	93230–32
Madera County:	93601, 93604, 93614, 93637–39, 93643–45, 93653, 93669
Mariposa County:	93623
Napa County:	94503, 94508, 94515, 94558–59, 94562, 94567, 94573–74, 94576, 94581, 94599
Placer County:	95602–04, 95648, 95650, 95658, 95661, 95663, 95677–78, 95681, 95703, 95722, 95736, 95746–47, 95765
Santa Clara County:	94022–24, 94035, 94039–43, 94085–90, 94301–02, 94304–06, 94309–10, 95002, 95008–09, 95011, 95013–15, 95020**–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95101–03, 95106, 95108–42, 95148, 95150–61, 95164, 95170–73, 95190–94, 95196 **The Bells Station community, which lies within Gilroy zip code 95020, is not in the service area
Sonoma County:	94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–09, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486-87, 95492
Sutter County:	95659, 95668, 95674, 95676
Tulare County:	93618, 93666, 93673
Yolo County:	95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
Yuba County:	95692, 95903, 95961

Southern California counties:	Orange and Los Angeles (except zip code 90704).

Portions of the following counties, as indicated by the zip codes below, are also within the service area:

Imperial:	92275
Kern:	93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93250–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–13, 93380–90, 93501–02, 93504–05, 93518–19, 93531, 93560–61, 93581
Riverside:	91752, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92253–55, 92258, 92260–64, 92270, 92274, 92276, 92282, 92292, 92320, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92595–96, 92599, 92860, 92877–83
San Bernardino:	91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758, 91761–64, 91784–86, 91798, 92252, 92256, 92268, 92277, 92278, 92284–86, 92305, 92307–08, 92313–18, 92321–22, 92324–26, 92329, 92333–37, 92339–41, 92345–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–94, 92397, 92399, 92401–08, 92410–15, 92418, 92420, 92423–24, 92427
San Diego:	91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91990, 92007–09, 92014, 92018–27, 92029–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–58, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92082–85, 92090–93, 92096, 92101–24, 92126–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–79, 92182, 92184, 92186–87, 92190–99
Tulare:	93261
Ventura:	91319–20, 91358–63, 91377, 93001–07, 93009, 93010–12, 93015–16, 93020–21, 93022, 93030–35, 93040, 93041–44, 93060–61, 93062–66, 93093, 93099

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente service area, you can receive virtually all of the benefits of this Plan at any other Kaiser Permanente facility. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described on page 41; and for emergency care obtained from any non-Plan provider, as described on page 32. 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 live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We removed the requirement that services must be needed to restore functional speech from the speech therapy benefit.

Changes to this Plan

- In Northern California your share of the non-Postal premium will increase by 17.8% for Self Only or 17.7% for Self and Family.
- In Southern California your share of the non-Postal premium will increase by 18.6% for Self Only or 18.6% for Self and Family.
- We cover therapeutic contact lenses for the condition of aniridia at no charge.
- We increased the copayment for orthopedic and prosthetic devices dispensed in a Plan medical office or pharmacy, or by a vendor from no charge to 20% of our allowance.
- We increased the copayment for podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan podiatrist, physiatrist, or orthopedist from no charge to 20% of our allowance.
- We increased the copayment for outpatient durable medical equipment items for use in the home that are dispensed in a Plan medical office or pharmacy, or by a vendor from no charge to 20% of our allowance.
- We increased the copayment for emergency services within and outside our service area from $35 per visit to $50 per visit.
- We increased the copayment for all covered emergency ambulance transportation from no charge per trip to a $50 copayment per trip.
- We increased the copayment for prescription drugs from $10 for all drugs to $10 for generic drugs and $20 for brand-name drugs. Also, if you request a brand-name drug when your physician prescribes a generic drug, you will pay full charges for that drug.
- Certain contraceptives such as injectable and internally implanted, time-release contraceptives and intrauterine devices are now covered at no charge when provided by a Plan medical office. Previously there was a $10 copayment.
- We clarified the Preventive care, adult benefit by removing the entry for blood lead level testing for adults because it is a test more typically done for children.
- If you have Medicare Part B benefits, we now require that you assign your Medicare Part B benefits to the Plan to receive covered services.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We changed the address for sending disputed claims to OPM.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at our Member Service Call Center at 1-800-464-4000.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/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. Health Plan contracts with The Permanente Medical Group, Inc., the Southern California Permanente Medical Group, and independent multispecialty groups of physicians to provide or arrange all necessary physician care for Plan members. Medical care is provided through physicians, nurse practitioners, and other skilled medical personnel working as medical teams at Kaiser Permanente facilities. We credential Plan providers according to national standards. Specialists in most major specialties are available as part of the medical teams for consultation and treatment. Other necessary medical care, such as physical therapy and laboratory and X-ray services, is also available. Plan physicians also arrange any necessary specialty care.

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

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. In Northern California, Kaiser Permanente offers comprehensive, affordable health care at 30 Plan facilities conveniently located throughout the San Francisco Bay, Sacramento, Stockton, and Fresno areas. These facilities include Medical Centers with full hospital facilities and Plan medical offices. The Southern California service area has 10 major Medical Centers and more than 90 medical offices conveniently located throughout the Southern California area.

The Plan's facility directory lists the Plan's facilities and services, with the locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling our Member Service Call Center at 1-800-464-4000. You should use this directory to:

- Receive more information about facility locations and services
- Receive information about how to get established with a Plan physician

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

What you must do to get covered care

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

- **Primary care**

Your primary care physician can be either a family practitioner, pediatrician, gynecologist, or internist. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. Please notify the Plan of the primary care physician you choose. If you need help choosing a primary care physician, call the Plan. You may change your primary care physician at any time. You are free to see other Plan physicians if your primary care physician is not available, and to receive care at other Kaiser Permanente facilities.

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a gynecologist, an optometrist, or our mental health and substance abuse Plan providers 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 (the physician may have to get an authorization or approval beforehand).

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

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

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

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

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

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

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or 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 Service Call Center immediately at 1-800-464-4000. 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 hospital benefit 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. In certain cases your primary care physician can arrange for specialty services through a process we call a referral. Your physician must write a referral for services such as neurology, orthopedics, rheumatology, endocrinology, and any service that will not be provided by Plan physicians.

If a Plan physician determines that a referral for medical care is necessary, those arrangements will be prepared in writing and in advance of such medical care. If you receive care outside the Plan without a referral, you will be responsible for those expenses. We encourage you to participate in your medical care and discuss any questions about our referral process with your primary care physician. If your request for referral is denied, please contact our Member Service Call Center at 1-800-464-4000 or refer to Section 8 of this brochure.

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, facility, pharmacy, etc., when you receive services. Example: When you see your primary care physician, you pay a copayment of $10 per office visit.

- **Deductible**

  We do not have a deductible.

  NOTE: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

- **Coinsurance**

  Coinsurance is the percentage of our allowance that you must pay for certain services you receive. Example: In our Plan, you pay 50% of our allowance for infertility services.

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

  If you do not pay your copayment at the time you receive services, we will bill you. You will be required to pay a $10 charge for each bill sent for unpaid services.

Your catastrophic protection out-of-pocket maximum for copayments and coinsurance

After your copayments and coinsurance total $1,500 per person or $3,000 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. You must continue to pay copayments or coinsurance for these services:

- Prescription drugs
- Dental services
- Contraceptive devices
- Chiropractic services
- The $25 charge paid for follow-up or continuing care outside the service area

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 10 for how our benefits changed this year and page 63 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-464-4000 or our website at www.kaiserpermanente.org/california.

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.
- Note: Instead of a $10 charge, you pay only $5 if you enroll in our Medicare+Choice Plan and assign your Medicare benefits to the Plan.

IMPORTANT

Benefit description	You pay
Diagnostic and treatment services	
Professional services of physicians and other health care professionals • In a physician's office • In an urgent care center • Second opinion within Plan • Consultations with specialists	$10 per office visit
• During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	Nothing
At home	Nothing

Lab, X-ray, and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	
Routine screenings, such as: • Total blood cholesterol • Colorectal cancer screening, including — Fecal occult blood test — Sigmoidoscopy—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 should consult with your physician to determine what is appropriate for you.	Nothing
Routine mammogram—covered for women age 35 and older, as follows: • Age 35 through 39, one during this five-year period • Age 40 through 64, one every calendar year • At age 65 and older, once every two consecutive calendar years Note: In addition to routine screening, we cover mammograms when medically necessary to diagnose or treat your illness.	Nothing
Routine immunizations, including but not limited to: • Tetanus-diphtheria (Td) booster—once every 10 years, ages 19 and over (except as provided for under childhood immunizations) • Influenza/Pneumococcal vaccines • Hepatitis vaccinations	Nothing

Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance* • *Travel*	*All charges*
Preventive care, children	**You pay**
• Well-child preventive care visits (23 months and younger) • Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations age 24 months and older, such as: —Eye exams to determine the need for vision correction —Ear exams to determine the need for hearing correction	$10 per office visit
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance*	*All charges*
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • First scheduled postnatal care visit Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We 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 nonroutine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c) for hospital benefits and Section 5(b) for surgery benefits.	Nothing
Not covered: • *Routine sonograms to determine fetal age, size, or sex*	*All charges*

Family planning	You pay
• Voluntary sterilization • Genetic counseling • Insertion of surgically implanted or injectable contraceptives Note: The following devices or contraceptives are provided at no charge: intrauterine devices (IUDs); implanted and injectable contraceptives; and time release contraceptives. Note: We cover oral contraceptives, cervical caps, and diaphragms under the prescription drug benefit.	$10 per office visit
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: — Intravaginal insemination (IVI) — Intracervical insemination (ICI) — Intrauterine insemination (IUI) Note: We cover fertility drugs under the prescription drug benefit.	50% of our allowance
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Assisted reproductive technology (ART) procedures, such as:* *— In vitro fertilization* *— Embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm and donor eggs and services related to their procurement and storage*	*All charges*
Allergy care	
Allergy testing, treatment, and injections	$3 per office visit
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy	Nothing for services provided by a non-physician provider
Note: We limit high-dose chemotherapy in association with autologous bone-marrow transplants to those transplants listed under Organ/Tissue Transplants on page 28.	
• Intravenous (IV)/Infusion therapy—Home IV and antibiotic therapy	$10 for services provided by a physician
• Respiratory and inhalation therapy	$10 per office visit
• Growth hormone therapy (GHT)	
Note: We cover human growth hormone under the prescription drug benefit.	
• Dialysis—hemodialysis and peritoneal dialysis	
Not covered:	*All charges*
• *Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered*	
Physical and occupational therapies	
We cover initial courses of therapy for up to two months per condition for:	$10 per outpatient visit
• 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	Nothing for inpatient
• Occupational therapy by occupational therapists to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life	
Note: We provide subsequent courses of therapy for up to two months if you show significant improvement in your condition.	
Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction.	
Not covered:	*All charges*
• *Long-term rehabilitative therapy*	
• *Exercise programs*	
Speech therapy	
We cover initial and subsequent courses of therapy for up to two months per condition for:	$10 per outpatient visit
• Speech therapy by speech therapists when medically necessary	Nothing for inpatient
Hearing services (testing, treatment, and supplies)	
Hearing testing	$10 per office visit

Not covered: • *Hearing aids* • *Hearing tests to determine the most appropriate hearing aid*	*All charges*
Vision services (testing, treatment, and supplies)	**You pay**
• Diagnosis and treatment of diseases of the eye • Eye refractions to determine the need for vision correction and provide a prescription for eyeglasses	$10 per office visit
Therapeutic contact lenses for the condition of aniridia for up to two lenses per eye in a 12-month period	Nothing
Not covered: • *Eyeglasses or contact lenses (except for the condition of aniridia)* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	$10 per office visit
Not covered: • *Cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, 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	
We cover internally implanted FDA-approved devices, including but not limited to: • Artificial joints • Pacemakers • Cochlear implants • Intraocular implants following cataract removal • Surgically implanted breast implants following a mastectomy Note: See Section 5(b) for coverage of the surgery to insert the device.	Nothing

We cover FDA-approved devices that are in general use and are required because of a defect in form or function of a permanently inoperative or malfunctioning body part, including but not limited to: • Artificial limbs and eyes and stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan podiatrist, physiatrist, or orthopedist • Enteral formula for members who require tube feeding per Medicare guidelines	20% of our allowance
Not covered: • *Comfort, convenience, or luxury equipment or features* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Shoes or arch supports, even if custom-made, except to treat diabetes-related complications when prescribed by a Plan podiatrist, physiatrist, or orthopedist*	*All charges*
Durable medical equipment (DME)	**You pay**
• During a covered stay in a Plan hospital or skilled nursing facility • Ostomy and urological supplies We limit coverage to the standard item that meets your medical needs consistent with our Plan DME formulary guidelines.	Nothing

For use in the home when intended to be used repeatedly. Includes but is not limited to: • Oxygen and oxygen dispensing equipment • Hospital beds • Wheelchairs including motorized when medically necessary • Crutches • Walkers • Blood glucose testing monitors and related supplies • Insulin pumps • Infant apnea monitors • Repairs and replacements resulting from normal use We limit coverage to the standard item that meets your medical needs consistent with our Plan DME formulary guidelines. We decide whether to rent or purchase the item, and choose the vendor. Note: We only provide DME in the Plan's service area.	20% of our allowance
Not covered: • *Comfort, convenience, or luxury equipment or features* • *Devices not medical in nature, such as sauna baths, exercise and hygiene equipment* • *Electronic monitors of the function of the heart or lungs, except for infant apnea monitors* • *Devices to perform medical tests on blood or other bodily substances or excretions, except diabetic testing equipment and supplies* • *Dental appliances* • *Experimental or research equipment* • *Modifications to the home or auto*	*All charges*
Home health services	**You pay**
• Home health care ordered by a Plan physician and provided by a registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), or home health aide • Services include oxygen therapy, intravenous therapy, and medications Note: We only provide these services in the Plan's service area.	Nothing

Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Services outside of our service area*	*All charges*
Chiropractic and alternative treatments	**You pay**
Chiropractic services covering the diagnosis or treatment of neuromusculoskeletal disorders limited to 20 visits per year. You can access services in the following ways: Chiropractic services are provided through American Specialty Health Plans (ASHP). You will have direct access to a participating ASHP chiropractor without the need to obtain a Plan physician referral. Participating chiropractors are listed in the ASHP Participating Provider Directory. Specific details of this chiropractic benefit are listed in the ASHP evidence of coverage/disclosure form. You phone the ASHP chiropractor you have selected for an initial examination. After the initial examination and except for chiropractic emergency services, your ASHP chiropractor is responsible to obtain authorization from ASHP for any additional chiropractic services on your behalf. ASHP will not cover any chiropractic services if you were referred through your Plan physician. NOTE: When necessary and prescribed by an ASHP chiropractor, you may receive up to $50 of chiropractic appliances per calendar year.	$15 per office visit
Not covered: • *Naturopathic services* • *Hypnotherapy*	*All charges*
Educational classes and programs	
• Education for specific conditions	Nothing
• Health education publications	Nothing
• Educational classes for a wide variety of subjects that do not relate directly to specific conditions	Nominal charges
Note: Call the Member Service Call Center at 1-800-464-4000 for information on classes near you.	

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

IMPORTANT

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

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

IMPORTANT

Benefit description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Treatment of burns • Normal pre- and post-operative care by the surgeon • Pre-surgical testing • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity • Voluntary sterilization (tubal ligation and vasectomy) • Insertion of internally implanted contraceptives and intrauterine devices (IUDs) Note: We cover contraceptive drugs and devices under the prescription drug benefit. • Treatment for sexual dysfunction or inadequacy • Insertion of internal prosthetic devices. See Section 5(a)—Orthopedic and prosthetic devices for device coverage information.	$10 per office visit when provided on an outpatient basis Nothing when provided on an inpatient basis

Not covered: • *Reversal of voluntary surgical sterilization* • *Routine treatment of conditions of the foot*	*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; birth marks; webbed fingers; and webbed toes • All stages of breast reconstruction surgery following a mastectomy, such as: — surgery to produce a symmetrical appearance on the other breast; — treatment of any physical complications, such as lymphedemas; and — breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per office visit when provided on an outpatient basis Nothing when provided on an inpatient basis
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 or dislocations of the jaw 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 • Medical and surgical treatment of TMJ • Other surgical procedures that do not involve the teeth or their supporting structures	$10 per office visit when provided on an outpatient basis Nothing when provided on an inpatient basis
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/Lung • Kidney • Kidney/Pancreas • Liver • Lung: Single—Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • 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 when provided on an outpatient basis Nothing when provided on an inpatient basis
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of non-human artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided during a surgical procedure • Hospital (inpatient) • Ambulatory surgery center (outpatient)	Nothing

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

IMPORTANT

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

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

IMPORTANT

Benefit description	You pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: Your physician may prescribe accommodation or private duty nursing care if it 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 • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Plan physicians' and surgeons' services and supplies, including consultation and treatment by specialists • Take-home items Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The conditions for which we will provide hospitalization include hemophilia and heart disease. The need for anesthesia, by itself, is not such a condition.	Nothing
Not covered: • *Custodial care and care in an intermediate care facility* • *Personal comfort items, such as barber services, guest meals, and beds* • *Private nursing care unless medically necessary* • *Inpatient dental procedures*	*All charges*
Outpatient hospital or ambulatory surgical center	**You pay**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Dressings, casts, and sterile trays • 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 benefit period when you need full-time skilled nursing care. Your benefit period begins when you enter a hospital or skilled nursing facility and ends when you have not been a patient in either a hospital or skilled nursing facility for 60 consecutive days. All necessary services are covered, including; • Bed, board, and general nursing care • Prescribed drugs and their administration, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility	Nothing
Not covered: • *Custodial care* • *Care in an intermediate care facility*	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member: • You must reside in the service area • Services are provided in the home • 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
Ambulance	
Professional ambulance service, including air ambulance, when medically appropriate	Nothing
Not covered: • *Transports that we determine are not medically necessary*	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT

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

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

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

You are covered for medical emergencies anywhere in the world. In a medical emergency, call 911. When the operator answers, stay on the phone and answer all questions.

Emergencies within our service area:

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

If you are within our service area, we will cover Out-of-Plan emergency care only if you reasonably believe that going to a Plan facility for treatment will cause a delay resulting in permanent damage to your health. If you need to be hospitalized in a non-Plan facility, the Plan must be notified as soon as reasonably possible. Call us toll free in California at 1-800-772-3532. The telephone number to call is also on your ID card. We will make arrangements for necessary continued hospitalization or for transferring you to a designated hospital.

Emergencies outside our service area:

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

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

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente Plan. The facilities 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 1-800-227-2415.

Benefit description	You pay
Emergency within our service area	
• Emergency room visit for emergency services Note: We waive the $50 if you are admitted to the hospital.	$50 per visit
Not covered: • *Elective care or non-emergency care* • *Urgent care at a non-Plan urgent care center*	*All charges*
Emergency outside our service area	
Emergency care as an outpatient or inpatient at a hospital, including physicians' services • Emergency room visit for emergency services • Emergency care at an urgent care center • 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.	$50 per visit The amount you would be charged if you were a member in that service area
Not covered: • *Elective care or nonemergency care at non-Plan facilities*	*All charges*
Ambulance	
Professional ambulance service, including air ambulance, when medically appropriate	$50 per trip
Not covered: • *Transports we determine are not medically necessary*	*All charges*

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

IMPORTANT

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

Mental health and substance abuse benefits	You pay
Diagnosis and treatment of psychiatric conditions, mental illness, and mental disorders. Services include: • Diagnostic evaluation • Treatment (including individual, family, and group therapy visits) • Crisis intervention and stabilization for acute episodes • Psychological testing that is medically necessary to determine the appropriate psychiatric treatment • Medication management and evaluation Diagnosis and treatment of alcoholism and drug abuse. Services include: • Treatment and counseling (including individual, family, and group therapy visits) • Outpatient detoxification (medical management of withdrawal from the substance) Note: You may see a Plan mental health or substance abuse provider for outpatient treatment without a referral from your primary care physician. Note: Your Plan provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you.	$10 per office visit
• Inpatient psychiatric care • Hospital alternative services, such as partial hospitalization and intensive outpatient psychiatric treatment programs • Inpatient substance abuse care and rehabilitation • Inpatient detoxification • Methadone treatment for a pregnant woman throughout the pregnancy and for two months after delivery Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan physician.	Nothing
Recovery services in a non-medical residential care facility Note: All inpatient and alternative services treatment programs require approval by a Plan physician.	$100 per stay

Mental health and substance abuse benefits	You pay
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *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*

Limitation We may limit your benefits if you do not obtain a treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

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

IMPORTANT

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

- **Who can write your prescription.** A Plan physician or any dentist must write the prescription. Drugs prescribed by dentists are not covered if a Plan physician determines that they are not medically necessary.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy or another pharmacy that we designate, or through our mail order program.
- **We use a formulary.** A formulary is a listing of preferred pharmaceutical substances and formulas. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. The Plan uses this formulary to determine which prescribed drugs will be provided to members.

  Our formulary includes a list of prescription drugs that have been approved by our Pharmacy and Therapeutics Committee. This committee, which is comprised of Plan physicians and other Plan providers, selects prescription drugs for the formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets quarterly to consider adding and removing prescription drugs on the formulary. If you would like information about whether a particular drug is included on our formulary, please call the Member Service Call Center at 1-800-464-4000.

  If the physician specifically prescribes a non-formulary drug because it is medically necessary, the non-formulary drug will be covered. If you request the non-formulary drug when your physician has prescribed a substitution, the non-formulary drug is not covered. However, you may purchase the non-formulary drug from a Plan pharmacy at prices charged to members for non-covered drugs.
- **These are the dispensing limitations.** We provide up to a 100-day supply for most drugs, except certain drugs that have a significant potential for waste will be provided for up to a 30-day supply in any 30-day period. Please contact our Member Service Call Center at 1-800-464-4000 for the current list of these drugs. Maintenance medications may be obtained for up to a 100-day supply when ordered through our mail-order program.
- **When you have to file a claim.** When you receive drugs from a Plan pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy.

Prescription drug benefits begin on the next page.

Benefit description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Certain self-administered IV drugs and fluids requiring specific types of parenteral infusion, and the supplies required for their administration • Amino acid-modified products used to treat congenital errors of amino acid metabolism • Diabetes urine-testing supplies • Vaccines and immunizations approved for use by the Food and Drug Administration • Elemental dietary enteral formula when used as a primary therapy for regional enteritis	Nothing
• Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary.	$10 per prescription for generic drugs
• Insulin • Certain insulin administration devices • Disposable needles and syringes for the administration of covered medications	$20 per prescription for brand-name drugs
• Smoking cessation drugs are covered for one course of treatment per calendar year, but only if you participate in, and pay the cost of, a Plan-approved behavioral intervention program	All charges if you request a brand-name drug in place of a generic drug
• Oral contraceptives	$10 per prescription for generic drugs and $20 per prescription for brand-name drugs (up to a 3-cycle supply); all charges if you request a brand-name drug in place of a generic drug
• Cervical caps and diaphragms	$20 per device
• Infertility drugs • Sexual dysfunction drugs — Episodic drugs will be provided up to a maximum of 27 doses in any 100-day period. Additional prescribed doses during the same 100 days will be dispensed at our allowance. — Maintenance drugs that require doses at regulated intervals	50% of our allowance

Covered medications and supplies	You pay
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins and nutritional supplements that can be purchased without a prescription* • *Nonprescription drugs, unless they are included in our drug formulary* • *Medical supplies, such as dressings and antiseptics* • *Drugs to enhance athletic performance*	*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. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services from other Kaiser Permanente Plans	When you are visiting in the service area of another Kaiser Permanente Plan, you are entitled to receive virtually all the benefits described in this brochure at any Kaiser Permanente medical office or medical center. You will have to pay the charges imposed by the Plan you are visiting. If the Plan you are visiting has a benefit that is different from the benefits of this Plan, you are not entitled to receive that benefit. Some services covered by this Plan, such as artificial reproductive services and the services of specialized rehabilitation facilities, will not be available in other Kaiser Permanente service areas. If a benefit is limited to a specific number of visits or days, you are entitled to receive only the number of visits or days covered by the Plan in which you are enrolled. If you are seeking routine, non-emergent, or non-urgent services, you should call the Kaiser Permanente Member Services Department in that service area and request an appointment. You may obtain routine follow-up or continuing care from these Plans, even when you have obtained the original services in the service area of this Plan. If you require emergency services as the result of unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care. At the time you register for services, you will be asked to pay the charges required by the local Plan. If you plan to travel to an area with another Kaiser Permanente Plan and wish to obtain more information about the benefits available to you from the Kaiser Permanente Plan, please call our Member Service Call Center at 1-800-464-4000.

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 or outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency and urgent care benefits and include: • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast. • Outpatient continuing care for conditions diagnosed by a Kaiser Permanente health care provider or affiliated Plan provider that have been treated within the previous 90 days. Services include childhood immunizations, dialysis, or prescription drug monitoring. • You pay $25 for each follow-up or continuing care office visit. This amount will be deducted from the payment we make to you. • Your benefit is limited to $1,200 each calendar year. • For more information about this benefit call 1-800-390-3509. • File claims as shown on page 45. *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*
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may talk with a registered nurse who will discuss treatment options and answer your health questions. You can obtain an advice nurse phone number for the nearest Kaiser Permanente facility in the white pages of your phone book under "Kaiser Permanente".
Services for deaf and hearing impaired	We provide a TTY/text telephone number—1-800-777-1370. Sign language services are also available.
Centers of excellence for transplants	Kaiser Permanente's National Transplant Network (NTN) was created to offer members greater choice of and access into Centers of Excellence (COE) that exceed minimum quality standards for experience (based on volume of cases and transplant team composition), outcomes, and service (waiting time and access to the Center). The goal is to ensure that members are treated at Centers where optimal outcomes can be expected, measured, and managed. Currently, the NTN contains 20 Centers that include 70 transplant programs. Transplant services provided through the NTN are heart, lung, heart/lung, liver, simultaneous kidney/pancreas, pancreas, small bowel, and bone marrow/stem cell (autologous and allogeneic).

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 are payable only when we determine they are dentally necessary.
- We cover hospitalization for dental procedures at a Plan hospital we designate only when a non-dental 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

We have no dental benefits.

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.

Eyewear discount

As a Kaiser Permanente FEHBP Member, you and your eligible dependents will be able to purchase eyewear at significant savings. When you visit any of the California Division Health Plan Optical Departments, you will receive 25 percent off our allowance for frames and lenses and options such as no-line bifocals and prescription and non-prescription sunglasses. You will also be able to receive 25 percent off our allowance for cosmetic contact lenses and the required lens fitting.

Limitations & exclusions: This discount will apply only to purchased eyewear under the FEHBP basic coverage. The vision discount may not be coordinated with any other Kaiser Permanente Health Plan vision benefit. This discount will also not apply to any sale, promotional, or packaged eyewear program or for any contact lens Extended Purchase Agreement (which includes products purchased in this Agreement).

Expanded dental benefits

Kaiser Permanente is pleased to offer federal employees, retirees, and dependents a choice of dental coverages to supplement your medical plan.

Option I/Delta Care
DeltaCare offers dental health maintenance organization (HMO) benefits that are administered by PMI, an affiliate of Delta Dental Plan of California. You select a dentist from the network of contracting DeltaCare dental offices that is most convenient for you and your family. With DeltaCare, there are no claim forms to worry about. DeltaCare also provides a full range of services that includes preventive, restorative, endodontics, periodontics, prosthetics, oral surgery, and orthodontics. Under this program, the subscriber pays a specific copayment for most covered services.

Option II/KPIC's Dental Plan
KPIC's Dental Plan, a table of allowances program, allows you to select any licensed dentist. After you satisfy a deductible, KPIC's Dental Plan will pay a predetermined amount that is specified in a table toward each covered service, and you pay the remainder of the fee. You do not need to satisfy a deductible toward covered preventive services you receive. KPIC's Dental Plan offers a full range of services; diagnostic, preventive, restorative, endodontics, periodontics, oral surgery, and both fixed and removable prosthodontics. Orthodontics is not available under the KPIC's Dental Plan.

Monthly Premium*	Option I/Delta Care		Option II/KPIC's Dental Plan
	Monthly Premium	Quarterly Premium	Monthly Premium
Self Only	$ 9.01	$27.02	$23.21
Self & One Party	$15.07	$45.21	$41.29
Self & Two or More	$22.85	$68.55	$62.06

KPIC's Dental Plan and DeltaCare are available only if you enroll or are currently enrolled in the Kaiser Permanente Plan for FEHB Members. You do not need to enroll in either dental plan if you choose not to. All subscribers who enroll in either dental program, when eligible, must continue enrollment in the selected dental program until the next open enrollment period. This does not apply if employment is terminated.

How to enroll
Please use the enclosed postage-paid card to send in your application. If you would like more information on KPIC's Dental Plan, please call 1-800-933-9312. A Delta Dental representative will be able to assist you Monday through Friday, 6 a.m. to 6 p.m.

Payments for the KPIC's Dental Plan or DeltaCare programs will be made by automatic withdrawal from your checking, savings, or credit union account.

* These rates are effective January 1, 2002 through December 31, 2002.

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, hospital, and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call our Member Service Call Center at 1-800-464-4000.

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:

Northern California service area:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923

Southern California service area:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7102
Pasadena, CA 91109-9880

Deadline for filing your claim

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

When we need more information

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

If you have a malpractice claim

If you have a malpractice claim because of services you did receive, or did not receive, from a Plan provider, you must submit the claim to binding arbitration. The Plan has the information that describes the arbitration process. Contact our Member Service Call Center at 1-800-464-4000 for copies of our requirements. These will explain how you can begin the binding arbitration process.

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within six months from the date of our decision; and (b) Send your request to us at: Kaiser Permanente, Member Relations, P.O. Box 12983, Oakland, CA 94604-2983; 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, 1900 E Street, NW, Washington, DC 20415-3630.

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 include 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 or from the year in which you were denied precertification or prior approval. 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 referral, then call us at 1-800-464-4000 and we will expedite our review; or

(b) We denied your initial request for care or a referral, 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 normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

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

- **What is Medicare?**

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.

- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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 (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The

Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, 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 **the Original Medicare Plan** or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary payer chart		
A. When either you, or your covered spouse, are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB,		✓
(Ask your employing office which of these applies to you.)		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation)	
B. When you, or a covered family member, have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of 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 another type of Medicare+Choice plan—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 provide all the benefits that Original Medicare covers. 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 have lowered or waived some of our copayments and coinsurance for your FEHB and Medicare coverage. If you would like information about our Medicare+Choice plan, please call 1-800-443-0815. Your Kaiser Permanente Senior Advantage-FEHBP benefits that we lowered or waived are:

- **Prescriptions:** $5 for each generic/formulary drug and $15 for each brand name drug for up to a 100-day supply. The same prices apply to mail-order drugs.
- **Physician office visits:** $5 for physician/specialist office visits
- **Preventive services:** $5
- **Routine physical and hearing exams:** $5 for one routine physical and hearing exam each year
- **Immunizations:** Pneumococcal pneumonia, flu, and Hepatitis B vaccines provided at no charge
- **Urgently needed care:** $5 for each visit to a Plan facility; $50 for each visit to a non-Plan facility in or out of the Plan's service area; Worldwide coverage
- **Vision services:**
  - — $5 for one routine eye exam each year
  - — $80 frame allowance, for one frame every two years
  - — Up to $124 allowance for cosmetic contact lenses in lieu of eyeglasses every 24 months
  - — $0 for lenses, for one pair every two years
- **Dental services:**
  - — $0 for oral exams or X-rays
  - — $15 for cleanings, up to two office visits each year
  - — No referral necessary for network providers
- **Chiropractic services:** Chiropractic care beyond what is covered by Medicare, including:
  - — $10 copayment for each office visit, up to 20 office visits each year
  - — No referral necessary for any network providers. Members must use ASHP Chiropractic providers

You will also enjoy:

- Health/Wellness Education: No copayments 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

You must use Kaiser Permanente Plan and affiliated providers and continue to pay Medicare premiums.

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 or lower any of our copayments or coinsurance. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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.

- **If you do enroll in Medicare Part B**

If you enroll in Medicare Part B, we require you to assign your Medicare Part B benefits to the Plan for its services.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B, and if you cannot get premium-free Part A, we will not ask you to enroll in it.

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 illness 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 care. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 14.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 14.

Covered services

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

Custodial care

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 14.

Durable medical equipment

Durable medical equipment (DME) is equipment that is 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 serves a specific therapeutic purpose in the treatment of an illness or injury.

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, Inc.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

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 can 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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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.

- **Temporary continuation of coverage (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, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. 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. It explains what you have to do to enroll.

- **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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB website (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked question. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG!*
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long-term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long-term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8-hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long-term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long-term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long-term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our website at www.opm.gov/insure/ltc.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2002. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

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

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

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

The demonstration areas

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

When you can join

You may enroll under the DoD/FEHB Demonstration Project during the 2001 open season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. DoD has set up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during open season. Your coverage will begin January 1, 2002. If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a website devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations, and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM website at www.opm.gov.

TCC eligibility

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

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

Other features

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

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of benefits for Kaiser Foundation Health Plan, Inc., California Division—2002

- **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	16
Services provided by a hospital:		
• Inpatient	Nothing	29
• Outpatient	Nothing	30
Emergency benefits:		
• In-area	$50 per visit	32
• Out-of-area	$50 per visit	32
Mental health and substance abuse treatment:	Regular cost sharing	34
Prescription drugs	$10 per prescription for generic drugs; $20 per prescription for brand-name drugs; all charges if you request a brand-name drug in place of a generic drug	37
Dental Care	No benefit	42
Vision Care	Refractions; $10 per office visit	21
Special features: Flexible benefits option; Services from other Kaiser Permanente Plans; Travel benefit; 24 hour nurse line; Services for deaf and hearing impaired; Centers of excellence for transplants		40
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,500/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	14

2002 rate information for
Kaiser Foundation Health Plan, Inc., California Division

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 and 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 who are not career postal employees. 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
Northern California							
Self only	591	$79.73	$26.58	$172.76	$57.58	$94.35	$11.96
Self and family	592	$190.34	$63.44	$412.40	$137.46	$225.23	$28.55
Southern California							
Self only	621	$83.98	$27.99	$181.95	$60.65	$99.37	$12.60
Self and family	622	$194.08	$64.69	$420.50	$140.17	$229.66	$29.11