Kaiser Foundation Health Plan of the Northwest

http://www.kp.org/nw

KAISER PERMANENTE®

2002

A Health Maintenance Organization

Serving: *Portland and Salem, Oregon*
Vancouver and Longview, Washington

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

This Plan has excellent accreditation from the NCQA. See the 2002 Guide for more information on accreditation.

Enrollment codes for this Plan:

571 High Option Self Only
572 High Option Self and Family
574 Standard Option Self Only
575 Standard Option 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 73-004

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Introduction

Kaiser Foundation Health Plan of the Northwest
500 N.E. Multnomah Street, Suite 100
Portland, Oregon 97232-2099

This brochure describes the benefits of Kaiser Foundation Health Plan of the Northwest under our contract (CS 1047) 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 9. 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 of the Northwest.

- 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 the structure of 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 receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us from Portland at 503/813-2000, or from other areas call 800/813-2000 or the TTY number at 800/324-8007 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

Kaiser Foundation Health Plan of the Northwest contracts with Northwest Permanente, P.C., to provide professional health care services. Northwest Permanente physicians provide approximately 98% of primary care services and more than 80% of specialty services to members. We reimburse Northwest Permanente for these services through an annually adjusted capitation rate, paid to the medical group as a whole. As employees of Northwest Permanente, individual physicians receive a salary. Northwest Permanente uses approximately 97% of the base capitation payment to pay physician salaries. An incentive compensation payment (ICP) of approximately 3% of the base capitation payment is at risk and is paid to physicians based on a combination of patient satisfaction, quality, and financial results.

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 website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

We are a federally qualified health maintenance organization. Kaiser Foundation Health Plan of the Northwest is a non-profit corporation. Kaiser Permanente began offering medical services to workers and their families at Grand Coulee Dam in northeastern Washington and later the Kaiser shipyards in Portland, Oregon and Vancouver, Washington during World War II. When the shipyards were closed in 1945, enrollment was opened to the community. This Plan is part of the Kaiser Permanente Medical Care Program, a group of not-for-profit organizations and contracting medical groups that serve over 8 million members nationwide.

In 1995, Kaiser Permanente became the first HMO in Oregon and southwest Washington to receive a three-year, full accreditation from the National Committee for Quality Assurance (NCQA). We were again awarded three-year, full accreditation in 1998. In 2001, we were awarded the highest level of accreditation, known as "Excellent Accreditation." Excellent Accreditation status is awarded to plans whose service and clinical quality meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement, and whose HEDIS (Health Plan Employer Data and Information Set) results are in the highest range of national performance.

All Kaiser Permanente and affiliated hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

All applicants for employment with Northwest Permanente P.C., or Permanente Dental Associates must meet rigorous Kaiser Permanente credentialing standards. Once hired, they undergo periodic review by peers and hospital boards to assure their credentials are up to date and in order.

If you want more information about us, from Portland, call 503/813-2000, or from other areas call 800/813-2000 or our TTY numbers in Oregon at 800/735-2900 and in Washington at 800/833-6388, or write to Kaiser Foundation Health Plan of the Northwest, 500 N.E. Multnomah Suite 100, Portland, OR 97232. You may also visit our website at www.kp.org/nw.

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:

These Oregon counties: Columbia, Multnomah, Polk, Yamhill

And these Oregon zip codes:

Benton County: 97330, 97331, 97333, 97339, 97370

Clackamas County: 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97055, 97067-68, 97070, 97222, 97267-68

Linn County: 97321, 97335, 97355, 97358, 97360, 97374, 97389

Marion County: 97002, 97020, 97026, 97032, 97071, 97137, 97301-3, 97305-14, 97325, 97352, 97359, 97362, 97375, 97381, 97383-85, 97392

Washington County: 97005-8, 97062, 97075-78, 97106, 97109, 97113, 97116-17, 97119, 97123-25, 97133, 97140, 97144, 97223-25, 97229, 97281, 97291

These Washington counties: Clark County

And these Washington zip codes:

Cowlitz County: 98581, 98603, 98609, 98611, 98616, 98625-26, 98632, 98645, 98649, 98674

Lewis County: 98591, 98593, 98596

Wahkiakum County: 98612, 98647

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 47 and for emergency care obtained from any non-Plan provider, as described on page 37. 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

- Your share of the non-Postal premium will increase by 2.2% for Self Only or 0.1% for Self and Family under the High Option and will increase by 12.0% for Self Only or 12.0% for Self and Family under the Standard Option.
- We increased your office visit copayment from $12 to $15 for medical services and supplies provided by physicians and other health care professionals (Standard Option only).
- We cover travel immunizations and medications.
- We cover both the diagnosis and treatment of infertility at 50% of our allowance for both the Standard and High Option.
- We cover orthopedic and some prosthetic devices at 50% of our allowance for both the Standard and High Option.
- We cover durable medical equipment at 50% of our allowance for both the Standard and High Option.
- We waive your non-plan emergency services copayment if you are admitted to a hospital directly from the emergency room.
- We increased the copayment for prescription drugs. For Standard Option, the copayment changes from $15 for all drugs to $15 for generic drugs and $30 for brand-name drugs. For High Option, the copayment changes from $10 for all drugs to $10 for generic drugs and $20 for brand-name drugs.
- We cover medications for foreign travel.
- You pay $25, in addition to applicable copayments, for emergency or urgent dental care received from a Plan dentist during regular business hours, after hours, or on weekends (High Option only).
- 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 obtain 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 from Portland at 503/813-2000, or from other areas call 800/813-2000 or our TTY numbers in Oregon at 800/735-2900 and in Washington at 800/833-6388.

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**

The Plan contracts with Northwest Permanente, P.C. to provide physician services. They practice in medical offices located within our service area. Permanente Dental Associates, an independent group of dentists, provides or arranges dental care for members of the High Option plan.

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. Medical Centers, Medical Offices and Dental Offices are conveniently located throughout Portland and Salem, Oregon and Vancouver and Longview-Kelso, Washington. Inpatient care is available at Kaiser Sunnyside Medical Center, Providence St. Vincent Medical Center, Providence Portland Medical Center, Southwest Washington Medical Center, Salem Hospital, St. John Medical Center, Doernbecher Children's Hospital (for children only), and Legacy Emanuel Hospital and Health Center (for low risk childbirth services). We list these in the provider directory, which we update periodically. The list is also on our website.

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Our website has information about our providers. Membership Services can help you too, by telling you who is available and sharing information about them. To choose or change a primary care physician, call Membership Services from Portland at 503/813-2000, or from other areas call 800/813-2000 or our TTY numbers in Oregon at 800/735-2900 and in Washington at 800/833-6388.

- **Primary care**

Your primary care physician can be a physician, nurse practitioner, or physician assistant in family practice, internal medicine, or pediatrics. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. 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, a woman may see her obstetrician/gynecologist without having to obtain a referral. You may also receive outpatient alcohol and drug treatment, cancer counseling, eye examinations, outpatient mental health, chiropractic, occupational health, and social work services without a referral.

Here are other things you should know about specialty care:

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

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

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

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

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

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

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

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

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can

continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Membership Services department immediately from Portland at 503/813-2000, or from other areas call 800/813-2000 or our TTY numbers in Oregon at 800/735-2900 and in Washington at 800/833-6388. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- you are discharged, not merely moved to an alternative care center; or
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan;

whichever happens first.

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

Circumstances beyond our control

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

Services requiring our prior approval

Most care and service is not subject to administrative prior authorization. Prior authorization is required for select services such as care at skilled nursing facilities, home health and hospice services, referrals to non-Kaiser Permanente physicians, and transplants. Your primary care physician will give a referral for these services if they are medically necessary.

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 if you are on the High Option Plan and $15 per office visit if you are on the Standard Plan. When you go in the hospital, you pay nothing under either Option.

- **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.

  And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

- **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 $6 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 $600 per person or $1,200 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum. You must continue to pay copayments for these services under both the High Option and Standard Option.

- Outpatient prescription drugs
- Contraceptive devices
- Dental services
- Corrective appliances and artificial aids
- The $25 charges paid for follow-up or continuing care when you are traveling out of our service area
- Long-term physical therapy and rehabilitation
- Eyeglasses and contact lenses
- Health education services

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 9 for how our benefits changed this year and page 70 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 from Portland at 503/813-2000, or from other areas call 800/813-2000 or our TTY numbers in Oregon at 800/735-2900 and in Washington at 800/833-6388 or at our website at www.kp.org/nw.

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: We waive the $10 charge 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	**You pay - Standard Option**	**You pay - High Option**
Professional services of physicians and other health care professionals • In a physician's office • Office medical consultations • In a Plan urgent care center • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Second surgical opinion	$15 per office visit	$10 per office visit
Professional services of physicians and other health care professionals • During a hospital stay	Nothing	Nothing
At home	Nothing	Nothing

Lab, X-ray, and other diagnostic tests	You pay - Standard Option	You pay - High Option
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing	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 and medically necessary for you. Note: You will pay only one copayment if you receive your routine screening on the same day as your office visit.	$15 per office visit	$10 office visit
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years Note: In addition to routine screening, we cover mammograms when medically necessary to diagnose or treat your illness.	Nothing	Nothing

Routine immunizations and boosters	Nothing	Nothing
Visits to receive injections	$5 per office visit	$5 per office visit
Injectable travel immunizations Note: We cover oral travel immunizations under the prescription drug benefit.	$15 per office visit	$10 per office visit
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance* • *Attending schools*	*All charges*	*All charges*
Preventive care, children	**You pay – Standard Option**	**You pay - High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Examinations, such as: —Eye exams to determine the need for vision correction —Ear exams to determine the need for hearing correction —Examinations done on the day of immunizations • Well-child care charges for routine examinations, immunizations, and care	$15 per office visit	$10 per office visit
Injectable travel immunizations Note: We cover oral travel immunizations under the prescription drug benefit.	$15 per office visit	$10 per office visit
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance* • *Attending schools or camp*	*All charges*	*All charges*

Maternity care	You pay - Standard Option	You pay – High Option
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your physician will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c) for hospital benefits and Section 5(b) for surgery benefits.	$15 per office visit	$10 per office visit
Not covered: • *Routine sonograms to determine fetal age, size, or sex*	*All charges*	*All charges*
Family planning		
• Family planning services including counseling • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: In addition to the office visit copay for surgical procedures related to Norplant and IUDs, we charge for the device according to your Prescription Drug benefit. Contraceptive drugs and diaphragms are also covered under your Prescription Drug benefit.	$15 per office visit	$10 per office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*

Infertility services	You pay - Standard Option	You pay - High Option
Diagnosis and treatment of involuntary infertility including artificial insemination limited to intrauterine insemination (IUI)	50% of our allowance	50% of our allowance
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Intravaginal insemination (IVI)* • *Intracervical insemination (ICI)* • *Assisted reproductive technology (ART) procedures, such as:* *—In vitro fertilization* *—Embryo transfer and gamete intrafallopian transfer (GIFT)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm and donor eggs and services related to their procurement and storage* • *Drugs used in the diagnosis and treatment of infertility*	*All charges*	*All charges*
Allergy care		
Testing and treatment	$15 per office visit	$10 per office visit
Allergy injections	$5 per office visit	$5 per office visit
Allergy serum	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*

Treatment therapies	You pay - Standard Option	You pay - High Option
• Chemotherapy and radiation therapy Note: We limit high dose chemotherapy in association with autologous bone marrow transplants to those transplants listed under Organ/Tissue Transplants on page 31. • Respiratory and inhalation therapy • Dialysis • Intravenous (IV)/Infusion Therapy – home IV and antibiotic therapy Note: We cover growth hormone therapy (GHT) under the Prescription Drug benefit on page 43.	$15 per office visit	$10 per office visit
Not covered: • *Long-term rehabilitative therapy* • *Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered* • *Cognitive therapy*	*All charges*	*All charges*
Physical and occupational therapies		
2 months of therapy per condition: • Physical therapy by qualified physical therapists to restore bodily function when you have a total or partial loss of bodily function due to illness or injury • Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction.	$15 per outpatient visit Nothing for inpatient	$10 per outpatient visit Nothing for inpatient
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy		
2 months of therapy per condition: • Speech therapy by speech pathologists when medically necessary	$15 per outpatient visit Nothing for inpatient	$10 per outpatient visit Nothing for inpatient

Not covered: *Speech therapy that is not medically necessary such as:* • *Therapy for educational placement or other educational purposes* • *Training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation* • *Therapy for tongue thrust in the absence of swallowing problems*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**You pay - Standard Option**	**You pay - High Option**
• Ear and hearing examinations to determine the need for hearing correction • Hearing testing for children through age 17 (see Preventive care, children)	$15 per office visit	$10 per office visit
Not covered: • *All other hearing testing* • *Hearing aids and supplies*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)		
• Diagnosis and treatment of diseases of the eye • Eye refractions	$15 per office visit	$10 per office visit
• One pair of eyeglasses (regular lenses and designated frames), or designated industrial safety glasses • Medically indicated contact lenses for: —Extremely high degrees of near or farsightedness —Distorted corneas which limit the best visual acuity with glasses —Visual error of the two eyes which are greatly different in power Note: You may select between the eyeglasses lenses or the contact lenses. You are not entitled to both.	The cost of eyeglasses, contact lenses, or industrial safety glasses less $25 The cost of contact lenses less $25	Nothing Nothing

• You may select non-medically indicated contact lenses instead of glasses	The cost of contact lenses less $25	The cost of contact lenses less a credit equal to the cost of regular lenses and designated frames
• Eyeglasses and contact lens(es) after cataract surgery with intraocular lens implant: —Medically necessary intraocular lenses —One pair of eyeglasses (regular lenses and designated frames); or —One pair of contact lenses	Nothing	Nothing
• Eyeglasses and contact lens(es) after cataract surgery not involving intraocular lens implant: —One pair of contact lenses and/or one pair of designated frames and regular lenses if both must be worn at the same time to provide a significant improvement in visual acuity or binocular vision not obtainable with regular lenses or contact lens(es) alone	Nothing	Nothing
What you should know: Vision care benefits are provided to members when prescribed by Plan physicians or optometrists and provided at Plan facilities and optical departments. Your vision care benefits for eyeglasses, industrial safety glasses or contact lenses renews every two years from the date you last received them. If a significant change in correction occurs in one or both eyes before the two years has elapsed, we cover regular lenses, designated safety lenses or medically necessary contact lenses instead of glasses with the new correction. If you have selected non-medically necessary contact lenses in lieu of lenses and frames, and a significant change in correction occurs in one or both eyes before the two years has elasped, we will cover replacement of non-medically necessary contact lenses.	The cost of the new lenses less $25	The cost of new lenses less a credit equal to the cost of regular lenses

Not covered: • *Sunglasses, prescription or plain* • *Athletic safety glasses* • *Photogrey, photosun, and tinted lenses* • *Two pairs of lenses and frames in lieu of bifocals in the same frames* • *Repair or replacement of broken, lost, or stolen lenses or frames* • *Contacts having no refractive value* • *Fitting and routine follow-up services for non-medically indicated contact lenses* • *Refractions for non-medically indicated contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy, Photorefractive Keratectomy and other refractive surgery such as Lasik surgery and evaluations for these procedures* • *Visual training*	*All charges*	*All charges*
Foot care	**You pay - Standard Option**	**You pay - High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	$15 per office visit	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails and similar routine treatment of conditions of the foot* • *Treatment of weak, strained or flat feet or bunions or spurs of any instability, imbalance or subluxation of the foot*	*All charges*	*All charges*

Orthopedic and prosthetic devices	You pay - Standard Option	You pay - High Option
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: See Section 5(c) for payment information and Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for nondental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	Nothing	Nothing
Maxillo-facial prosthetic devices to restore or manage head and facial structures that are defective	20% of our allowance	20% of our allowance
When prescribed by a Plan physician, we cover orthopedic and other prosthetic devices not listed above, including repairs, adjustments or replacements other than those necessitated by misuse or loss. Note: We cover only those standard items that are adequate to meet the medical needs of the member. Note: Orthopedic and other prosthetic devices are provided in accordance with the Plan's DME formulary and its guidelines.	50% of our allowance	50% of our allowance

Not covered: • *Devices used primarily for cosmetic purposes that are not necessary to control or eliminate infection, pain, or restore functions such as speech, swallowing, or chewing* • *Artificial larynxes* • *Voice machines* • *Artificial hearts* • *Internally implanted insulin pumps* • *Dentures (except High Option)* • *External and internally implanted hearing aids* • *Devices, equipment, supplies, and prosthetics related to the treatment of sexual dysfunction* • *Orthopedic devices including corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*	*All charges*
Durable medical equipment (DME)	**You pay - Standard Option**	**You pay – High Option**
When prescribed by a Plan physician, we cover or purchase, at our option, durable medical equipment intended to be used repeatedly and in the home. Necessary repairs, adjustments, and replacements other than those necessitated by misuse or loss are also covered. Note: We cover only those standard items that are adequate to meet the medical needs of the member. Note: DME-related supplies are provided in accordance with the Plan's DME formulary and its guidelines. Note: DME-related supplies for the treatment of diabetes are covered under your Prescription Drug benefit.	50% of our allowance	50% of our allowance

Home health services	You pay - Standard Option	You pay – High Option
If you are homebound and reside in the service area: • You may receive home health services of nurses and health aides, physical or occupational therapists, and speech and language pathologists, when prescribed by your plan physician, who will periodically review the program for continuing appropriateness and need • Services include oxygen therapy, intravenous therapy, and medications	Nothing	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 our service area*	*All charges*	*All charges*
Chiropractic		
Chiropractic services up to 20 visits per calendar year • Services include evaluation and management, musculoskeletal treatments, physical therapy modalities such as hot and cold packs, and X-rays Note: You must choose the chiropractor from our list of Participating Chiropractors. Contact us to get the list. You may see a chiropractor without referral from your Plan physician.	$20 per office visit	$15 per office visit
Not covered: • *Non-neuroskeletal disorders* • *Vocational rehabilitation services* • *Laboratory services; MRI or other type of advanced diagnostic radiology* • *Durable medical equipment or supplies for use in the home*	*All charges*	*All charges*
Alternative treatments		
No benefit	*All charges*	*All charges*

Education classes and programs	You pay - Standard Option	You pay – High Option
No Benefit	*All charges*	*All charges*

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 PRE-AUTHORIZATION FOR SOME SURGICAL PROCEDURES. Please refer to the pre-authorization shown in Section 3 to be sure which services and surgeries require pre-authorization.	IMPORTANT

Benefit Description	You pay	
Surgical procedures	**You pay – Standard Option**	**You pay - High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • 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 -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See Section 5(a) Orthopedic and prosthetic devices for coverage information	$15 per office visit for outpatient services Nothing for inpatient services	$10 per office visit for outpatient services Nothing for inpatient services

• Voluntary sterilization (tubal ligation and vasectomy) • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs). Note: In addition to the office visit copay, we charge the prescription drug copayment for the device. • Treatment of burns	$15 per office visit for outpatient services Nothing for inpatient services	$10 per office visit for outpatient services Nothing for inpatient services
Not covered: • *Reversal of voluntary sterilization*	*All charges*	*All charges*
Reconstructive surgery	**You pay – Standard Option**	**You pay - High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: —the condition produced a major effect on the member's appearance; and —the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities, cleft lip, cleft palate, birthmarks, webbed fingers, and webbed toes. • 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 covered at no charge (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.	$15 per office visit for outpatient services Nothing for inpatient services Nothing	$10 per office visit for outpatient services Nothing for inpatient services Nothing

Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**You pay - Standard Option**	**You pay – High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	$15 per office visit for outpatient services Nothing for inpatient services	$10 per office visit for outpatient services Nothing for inpatient services
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*

Organ/tissue transplants	You pay - Standard Option	You pay - High Option
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 Note: We cover related medical and hospital expenses of the donor when we cover your transplant.	$15 per office visit for outpatient services Nothing for inpatient services	$10 per office visit for outpatient services Nothing for inpatient services
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of non-human or artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*

Anesthesia	You pay - Standard Option	You pay – High Option
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office	Nothing	Nothing

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

IMPORTANT		IMPORTANT

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

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

Benefit Description	You pay	
Inpatient hospital	**You pay - Standard Option**	**You pay - High Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets NOTE: Your physician may prescribe private accommodations or private duty nursing care if it is medically necessary. If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing	Nothing

Inpatient hospital	You pay - Standard Option	You pay - High Option
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 • Pre-surgical testing • Costs associated with blood donated by you for a scheduled covered surgery • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • 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	Nothing
Not covered: • *Custodial care* • *Non-covered facilities,* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Any inpatient dental procedures*	*All charges*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay - Standard Option	You pay - High Option
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, and blood products • Blood and blood plasma • Costs associated with blood donated by you for a scheduled covered surgery • Dressings, casts, and sterile tray services • Medical supplies • Anesthetics and anesthesia service	Nothing	Nothing
Not covered: • *Collection, processing, and storage of blood donated by donors designated by you or a family member*	*All charges*	*All charges*
Extended care benefits/skilled nursing care facility benefits		
Up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate. We cover the following: • Room, board, and general nursing care • Prescribed drugs and their administration, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility	Nothing	Nothing
Not covered: • *Custodial care* • *Care in an intermediate care facility* • *Personal comfort items such as telephone or television*	*All charges*	*All charges*

Hospice care	You pay - Standard Option	You pay - High Option
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	Nothing
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*	*All charges*
Ambulance		
• Local professional ambulance service when medically appropriate	$25 per transport	$25 per transport
Not covered: • *Transports that we determine are not medically necessary*	*All charges*	*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:

If you have an 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 admitted to a non-Plan facility, call the Patient Transfer Coordinator from Portland at 503/813-4540. From all other areas dial 877/813-5993 and ask for the Patient Transfer Coordinator. You must notify the Plan as soon as is reasonably possible. If you are hospitalized in a non-Plan facility and Plan physicians believe your care can be better provided in a Plan facility, you will be transferred when medically feasible.

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

Emergencies outside our service area:

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

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

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local telephone book under Kaiser Permanente. These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling the Membership Services department from Portland at 503/813-2000, or from other areas call 800/813-2000 or our TTY numbers in Oregon at 800/735-2900 and in Washington at 800/833-6388.

Benefit Description	You pay	
Emergency within our service area	**You pay - Standard Option**	**You pay – High Option**
Emergency care as an outpatient or inpatient at a hospital, including physicians' services		
• At a physician's office	$15 per visit	$10 per visit
• At a Plan urgent care center	$15 per visit	$10 per visit
• In a Plan hospital emergency room	$50 per visit	$50 per visit
Note: We waive your copayment if you are admitted to a Plan hospital.		
Emergency care in a non-Plan hospital emergency room or urgent care center	$100 per visit	$100 per visit
Not covered:	*All charges*	*All charges*
• *Elective care or non-emergency care*		
Emergency outside our service area		
Emergency care as an outpatient or inpatient at a hospital, including physicians' services		
• At a physician's office	$100 per visit	$100 per visit
• At an urgent care center	$100 per visit	$100 per visit
• In a hospital emergency room	$100 per visit	$100 per visit
• In a Kaiser Foundation hospital in another Kaiser Foundation Health Plan service area	The amount you would be charged if you were a member in that service area	The amount you would be charged if you were a member in that service area
Note: We waive your copayment if you are admitted to a hospital.		
Note: See the Travel Benefit for coverage of continuing or follow-up care.		
Not covered:	*All charges*	*All charges*
• *Elective care or non-emergency care*		
• *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*		
• *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*		

Ambulance	You pay - Standard Option	You pay – High Option
Professional ambulance service, including air ambulance, when medically appropriate. See Section 5(c) for non-emergency service.	$25 per transport	$25 per transport
Not covered: • *Transports we determine are not medically necessary*	*All charges*	*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	**You pay - Standard Option**	**You pay – High Option**
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	Your cost sharing responsibilities are no greater than for other illnesses or conditions

Mental health and substance abuse benefits	You pay - Standard Option	You pay – High Option
Diagnosis and treatment of psychiatric disorders, mental illness or disorders of children, adolescents, and adults. Services include: • Diagnostic evaluation • Treatment services (including individual and group therapy visits) • Crisis intervention and stabilization for acute episodes • Psychological testing necessary to determine the appropriate psychiatric treatment • Medication evaluation and management Diagnosis and treatment of chemical dependency. Services include: • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) Note: Your mental health or substance abuse provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse. Note: You may see a Plan outpatient mental health or chemical dependency provider without a referral from your primary care physician.	$15 per office visit	$10 per office visit
• Inpatient psychiatric care • Inpatient care • Residential treatment Note: All inpatient admissions and hospital alternative services treatment programs require pre-approval by a Plan physician.	Nothing	Nothing
• Intensive outpatient psychiatric treatment programs Note: These services must be pre-approved by a Plan physician.	$50 per day up to a maximum of $250 per episode or course of treatment	$50 per day up to a maximum of $250 per episode or course of treatment

Mental health and substance abuse benefits	You pay - Standard Option	You pay – High Option
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Services we have not approved* • *Intelligence, IQ, aptitude ability, 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* • *Marital, family, or educational services* • *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 that may be present*	*All charges*	*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 or referral physician, your primary care provider, or licensed dentist must write the prescription.
- **Where you can obtain them**. You must fill the prescription at a Plan pharmacy, 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. These preferred drugs are included on our formulary. If your physician feels that a non-formulary drug is the most appropriate therapy to meet your individual medical needs, your physician may make an exception based on one of the following:

    1. You are intolerant of formulary alternatives.
    2. You have experienced treatment failure with formulary alternatives.
    3. You are allergic to formulary alternatives.
    4. You are a new member currently using a non-formulary drug. (A transition period is available while new members switch to the formulary alternative.)
    5. The non-formulary drug is for a dosage form or strength used in titrating a dose. (Titration is the process of gradually shifting a patient from one dosage level to another.)

- **These are the dispensing limitations.** We provide up to a 30-day supply. Maintenance medications may be obtained for up to a 90-day supply when ordered through our mail order program.
- **Why use generic drugs?** The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your plan less money than a name-brand drug.
- **When you have to file a claim.** When you receive drugs from a Plan pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy.

Prescription drug benefits begin on the next page.

Benefit Description	You pay	
Covered medications and supplies	**You pay - Standard Option**	**You pay - High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs for which a prescription is required by law • Oral contraceptive drugs • Insulin • Glucose test strips • Disposable needles and syringes for administration of covered prescribed medications • Smoking cessation drugs and medication, including prescribed nicotine gum and patches, when used in conjunction with smoking cessation programs • Chemotherapy • Certain over-the-counter medications prescribed by a Plan physician and listed on the Plan's formulary as the most appropriate treatment for a particular condition • Diaphragms and cervical caps • Drugs for foreign travel	$15 per prescription or refill for generic drugs $30 per prescription or refill for brand-name drugs	$10 per prescription or refill for generic drugs $20 per prescription or refill for brand-name drugs
• Intrauterine devices • Implanted time release drugs Note: We do not refund any portion of the copayment if you request removal of the implanted device or time-release medication before the end of its expected life.	$15 for generic drugs or $30 for brand-name drugs times the number of months the device or medication is expected to be effective, or 50% of our allowance, whichever is less up to $200	$10 for generic drugs or $20 for brand-name drugs times the number of months the device or medication is expected to be effective, or 50% of our allowance, whichever is less up to $200
• Injectable contraceptives	$15 for generic drugs or $30 for brand-name drugs times the number of months the medication is expected to be effective, or 50% of our allowance, whichever is less	$10 for generic drugs or $20 for brand-name drugs times the number of months the medication is expected to be effective, or 50% of our allowance, whichever is less

Covered medications and supplies	You pay - Standard Option	You pay - High Option
• Diabetic supplies such as external insulin pumps, infusion devices, glucose monitors, and diabetic foot care appliances • Drugs to treat sexual dysfunction. Note: These drugs have dispensing limitations. Contact the Plan for details.	50% of our allowance	50% of our allowance
• Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU) • Immunosuppressive drugs required after a transplant • Intravenous fluids and medication for home	Nothing	Nothing
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available, except those listed on the Plan's formulary and prescribed by a Plan physician* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Vitamins and nutritional supplements that can be purchased without a prescription* • *Medical supplies such as dressings and antiseptics* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs used in the diagnosis and treatment of infertility* • *Drugs related to non-covered services* • *Drugs used for weight management*	*All charges*	*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.
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call from Portland at 503/813-2000, or from other areas call 800/813-2000 or our TTY numbers in Oregon at 800/735-2900 and in Washington at 800/833-6388, and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	We provide TTY/text telephone numbers - in Oregon at 800/735-2900 and in Washington at 800/833-6388. Sign language services are also available.
Language interpretation	Interpreters are available to assist non-English speaking members. Please see the listing in your Medical Directory.
High risk pregnancies	Starring Health Babies was born August 1995 in response to the need for a comprehensive program to prevent pre-term birth. Our program works with you to • Increase the gestational age of newborns and decrease our premature birth rate though prevention and education. • Decrease the length of stay our infants require in the Neonatal Intensive Care Unit due to premature birth. • Decrease the amount of time our high-risk mothers need to spend in the hospital during their pregnancies by helping with their care at home. All pregnant Kaiser Permanente members are screened at their prenatal appointments or at an urgent hospital visit. We enroll those identified as being high risk for pre-term labor and assign them to their own case manager.

Feature	Description
Centers of excellence for transplants	The Centers of Excellence program began in Fall 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted "centers of excellence" for certain specialized medical procedures. We have developed a network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.
Travel benefit	Kaiser Permanente's travel benefits for Federal employees provide you with outpatient follow-up or continuing medical care when you are outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency and urgent care benefits and include: • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast. • Outpatient continuing care for conditions diagnosed by a Kaiser Permanente health care provider or affiliated Plan provider that have been treated within the previous 90 days. Services include childhood immunizations, dialysis, or prescription drug monitoring. • You pay $25 for each follow-up or continuing care office visit. This amount will be deducted from the payment we make to you. • Your benefit is limited to $1200 each calendar year**.** • For more information about this benefit call 800/390-3509. • File claims as shown on page 55. *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*

Feature	Description
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 this Plan. If you are seeking routine, non-emergent, or non-urgent services, you should call the Kaiser Permanente Membership Services department in that service area and request an appointment. You may obtain routine follow-up or continuing care from these Plans, even when you have obtained the original services in the service area. If you require emergency services as the result of unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care. At the time you register for services, you will be asked to pay the charges required by the local Plan. If you 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 Membership Services at 503/813-2000 or 800/813-2000.

Section 5 (h). Dental benefits

IMPORTANT		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 dentally necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures at a Plan hospital we designate subject to pre-authorization 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.
- 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: You will have to pay $10 for each missed appointment, unless you notify the dental office in advance.

Dental Benefits

Service	You pay - Standard Option	You pay - High Option
Members who have elected the High Option Plan will receive a comprehensive range of dental services as described below. All services must be prescribed by Plan dentists and provided at Plan dental offices. Note: These benefits are not covered under the standard option. Members covered under Standard Option may use Kaiser Dental facilities only as appointment access permits.	No benefit	See below
Diagnostic services and preventive care including: • Routine oral examinations • X-rays • Routine teeth cleaning and topical application of fluoride when prescribed by a Plan dentist, but not more than two visits in any twelve-month period • Prescribed space maintainers and habit appliances	*All charges*	$10 per office visit

Service	You pay - Standard Option	You pay - High Option
Basic Restorative Services including basic restorative services resulting from accidental injury as follows: • Amalgam (silver) restorations in posterior teeth and anterior teeth • Synthetic (plastic, resin and glass ionomer) restorations in all primary teeth, anterior teeth and one-surface restorations of posterior permanent teeth • Stainless steel or plastic crowns when amalgam or synthetic restorative materials are not professionally appropriate • If a member requests a procedure or material in excess of that recommended by a Plan dentist, the desired procedure or material may be provided upon payment of charges that reflect the additional value of providing the procedure or material, only if a Plan dentist agrees to perform the service Major Restorative Services as follows: • Placement of crowns, inlays, bridge pontics, or other cast metal restoration when prescribed by a Plan dentist • If a member requests a procedure or material in excess of that recommended by a Plan dentist, the desired procedure or material may be provided upon payment of charges that reflect the additional value of providing the procedure or material, only if a Plan dentist agrees to perform the service Note: We do not cover repair or replacement of existing cast crowns, inlays, bridge pontics, or other cast metal restorations less than five years after the date of the most recent placement or replacement. Oral Surgery Services as follows: • Diagnosis, evaluation, consultation, and treatment for removal of teeth (including local anesthesia) • Minor surgical preparation of mouth for insertion of dentures • Surgical treatment normally performed by a dentist for minor pathological conditions	*All charges*	$10 per office visit plus 50% of our allowance

Service	You pay - Standard Option	You pay - High Option
Periodontal Services as follows: • Diagnosis, evaluation, consultation, and treatment for diseases of tissues supporting the teeth including all follow-up cleaning visits Endodontic Services as follows: • Diagnosis, evaluation, consultation, and treatment for root canal therapy Prosthetics Appliances as follows: • Diagnosis, evaluation, consultation, and treatment for removable prosthetics, including full or partial dentures, relines, and rebases Note: If the removable appliance cannot be satisfactorily repaired or adjusted, then we cover a new prosthetic appliance only if the existing appliance is more than 5 years old.	*All charges*	$10 per office visit plus 50% of our allowance
Emergency or Urgent Care Note: This copayment applies for emergency or urgent dental care received from a Plan dentist at Plan dental offices. Note: All other applicable copayments apply.	*All charges*	$25 per office visit
Out-of-Area Emergency Care Note: The Plan pays up to $100 for emergency care for relief of pain, acute infection, or hemorrhage, or necessary treatment (including local anesthesia and pre-medication) due to injury.	*All charges*	All charges exceeding $100
Prescription Drugs Covered under Prescription Drug benefits		
Nitrous Oxide	*All charges*	$15 per occurrence
Adults and children over 12 years of age	*All charges*	Nothing
Children 12 years of age and under		
Nightguards	*All charges*	10% of our allowance

Service	You pay - Standard Option	You pay - High Option
Not covered: • *Orthodontics* • *Dental treatment for problems of the jaw joint, including temporomandibular joint syndrome/ craniomandibular disorders; or other conditions of the joint linking the jaw bone and skull, and of the complex of muscles, nerves, and other tissues related to that joint* • *Dental implants, including bone augmentation and the fixed or removable prosthetic devices attached to or covering the implants; and all services and materials relating to the placement or removal of implants including, but not limited to, diagnostic consultations, impressions, oral surgery, and removal of implants for cleaning; and dental services related to post-operative conditions or complications arising from implants* • *Restorative or reconstructive services for congenital or developmental malformations* • *Full mouth reconstructions. This includes appliances, restoration, and procedures needed to alter vertical dimension or occlusion, or in conjunction with alteration of vertical dimension or occlusion or for the purpose of splinting teeth or correcting attrition or abrasion.* • *Cosmetic dental services, including replacement of cosmetic dental restoration* • *Restoration replacement. Clinically acceptable restorations or material will not be removed or replaced with alternative materials unless a pathological condition of the teeth exists* • *IV sedation* • *Genetic testing* • *Replacement of pre-fabricated, non-cast crowns, including stainless steel crowns, which have not been placed by a Kaiser Permanente dentist* • *Replacement of removable appliances or night guards which are lost or stolen within 5 years of the date the member received the appliance*	*All charges*	*All charges*

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

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

Classes to change your lifestyle and keep you healthy

At Kaiser Permanente, we actively encourage you to share responsibility for your health care. Choices you make every day, about what you eat and drink, whether you exercise or smoke, how you handle stress, or whether you wear a seat belt, are tied directly to your health. They affect your chances of having a stroke or a heart attack, getting cancer, or being at risk for handicapping injuries.

We have developed a wide range of health education and health promotion classes to help you stay healthy. You can learn how to kick the smoking habit for good, effectively manage your weight, improve personal and family relationships, deal more effectively with a chronic health problem, have a safe and healthy pregnancy, and much more. Descriptions of the Non-Dieting Weight Management and Freedom from Cigarettes classes are shown below. Over 40 other classes are also offered. Class fees begin as low as $3 per member for some classes.

Our classes are open to everyone, but we offer them at special reduced rates to our members. If you would like to enroll, you must fill out a registration form. For the latest class catalog, call:

Health Education
Portland 503/286-6816
8 am – 5 pm, Monday-Friday
Salem 503/316-2344
Washington 360/604-2070

Membership Services
Portland 503/813-2000
8 am – 6 pm, Monday-Friday
All other areas 800/813-2000
8 am – 6 pm, Monday-Friday

Non-Dieting Weight Management

Healthy Weight Kit is an interactive guide to health weight management. It includes a resource guide, workbook, and more!

Healthy Weight Kit Class is a 5-week program using the Healthy Weight Kit.

Freedom from Diets is a 12-week program led by dieticians. It is a lifestyle approach to weight management, developed by Kaiser Permanente researchers.

Freedom from Cigarettes

The "cold turkey" approach to stop smoking or chewing tobacco. Learn the latest and most effective techniques for kicking the smoking habit for good. Sessions include:

- Relaxation techniques
- Understanding cigarette addiction
- Practicing effective ways to remain a non-smoker

Freedom from Cigarettes with Temporary Drug Therapy

These classes are designed to provide you with techniques and support that will increase your chances for lifelong freedom from tobacco. The participants must be appropriate for this Program:

Drug therapy has been proven to be most successful when used in conjunction with a behavior change program. The medication treatment is a short-term aid for people committed to learning how to stop smoking or chewing, and who have been unsuccessful with other methods.

Your present pharmacy benefit provides coverage for smoking cessation drugs, nicotine gum, and patches when used in conjunction with this program.

Benefits on this page are not part of the FEHB contract.

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, hospital, and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us from Portland at 503/813-2000, or from other areas call 800/813-2000 or our TTY numbers in Oregon at 800/735-2900 and in Washington at 800/833-6388.

When you must file a claim – such as for out-of-area care – please complete the Emergency Care Information (ECI) form and submit it with the HCFA-1500 or a claim form that includes the information shown below. ECI forms may be obtained by calling us from Portland at 503/813-2000, or from other areas call 800/813-2000 or our TTY numbers in Oregon at 800/735-2900 and in Washington at 800/833-6388. 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:

Claims Administration
Kaiser Foundation Health Plan of the Northwest
500 N.E. Multnomah, Suite 100
Portland, Oregon 97232-2099

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Kaiser Foundation Health Plan of the Northwest, 500 N.E. Multnomah, Suite 100, Portland, Oregon 97232-2099; 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 20415-3620.

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 approval, then call us from Portland at 503/813-2000, or from other areas call 800/813-2000 or our TTY numbers in Oregon at 800/735-2900 and in Washington at 800/833-6388 and we will expedite our review; or

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

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

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

- **What is Medicare?**

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. 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 waive or lower some of our copayments and coinsurance for your FEHB and Medicare coverage. If you would like information about our Medicare+Choice plan, please call from Portland 503/813-2000 or from other areas 800/813-2000 or our TTY numbers in Oregon at 800/735-2900 and in Washington at 800/833-6388. Your Kaiser Permanente Senior Advantage-FEHBP benefits that we lowered or waived are:

- Primary and Specialty care visits such as physical exams, allergy testing and injections, respiratory therapy, radiation therapy, same-day outpatient surgery, gynecological visits, hearing and vision exams, and manual manipulation of the spine: $0
- Dialysis: $0
- Hospital care: $0
- Durable medical equipment: $0
- Family planning: $0
- Home health care: $0
- Hospice care: $0
- House calls: $0
- Medical social services: $0
- Mental health and substance abuse: inpatient and outpatient services (residential/day treatment does have a copay): $0
- Physical, occupational and speech therapy, and rehabilitation services: $0
- Prosthetic and orthotic devices, ostomy, and urological supplies: $0
- Reconstructive therapy: $0
- Skilled Nursing Facility care: up to 100 days per benefit period: $0
- Transplants: $0
- Vision exams: $0
- X-ray, lab tests, and other special procedures: $0

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

Copayment

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

Covered services

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

Custodial care

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

Deductible

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

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 of the Northwest.

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 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. Conversion to an individual dental plan is not available.

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.

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 of the Northwest – Standard Option – 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.....	$15 per office visit	15
Services provided by a hospital:		33
• Inpatient.....	Nothing	
• Outpatient.....	Nothing	35
Emergency benefits:		38
• In-area	$50 per visit	
• Out-of-area	$100 per visit	38
Mental health and substance abuse treatment:	Regular cost sharing	40
• Prescription drugs.....	$15 per prescription or refill for generic drugs $30 per prescription or refill for brand-name drugs	44
Dental Care.....	No current benefit	NA
Vision Care.....	Refractions; $15 per office visit	21
Special features: Flexible benefits option; 24 hour nurse line; Services for deaf and hearing impaired; Language interpretation; High risk pregnancies; Centers of excellence for transplants; Travel benefit; Services from other Kaiser Permanente Plans		46
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $600/Self Only or $1200/Family enrollment per year Some costs do not count toward this protection	13

Summary of benefits for Kaiser Foundation Health Plan of the Northwest – High Option – 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	15
Services provided by a hospital:		33
• Inpatient.....	Nothing	
• Outpatient.....	Nothing	35
Emergency benefits:		38
• In-area	$50 per visit	
• Out-of-area	$100 per visit	38
Mental health and substance abuse treatment:	Regular cost sharing	40
• Prescription drugs.....	$10 per prescription or refill for generic drugs $20 per prescription or refill for brand-name drugs	44
Dental Care.....	Various copays based on procedure rendered	49
Vision Care.....	Refractions; $10 per office visit	21
Special features: Flexible benefits option; 24 hour nurse line; Services for deaf and hearing impaired; Language interpretation; High risk pregnancies; Centers of excellence for transplants; Travel benefit; Services from other Kaiser Permanente Plans		46
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $600/Self Only or $1200/Family enrollment per year Some costs do not count toward this protection	13

2002 Rate Information for
Kaiser Foundation Health Plan of the Northwest

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, 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
High Option Self Only	571	$97.86	$36.24	$212.03	$78.52	$115.52	$18.58
High Option Self and Family	572	$223.41	$84.34	$484.06	$182.73	$263.75	$44.00
Standard Option Self Only	574	$90.00	$30.00	$195.00	$65.00	$106.50	$13.50
Standard Option Self and Family	575	$206.55	$68.85	$447.53	$149.17	$244.42	$30.98