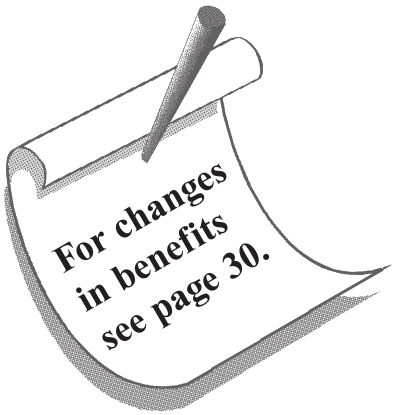
Kaiser Foundation Health Plan, Inc.
California Division 1999

KAISER PERMANENTE

A Health Maintenance Organization



Serving: Northern/Southern California service area

Enrollment in this Plan is limited; see page 10 for requirements.

Enrollment code:
591 Self only
592 Self and family

This Plan has full accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA

Enrollment code:
621 Self only
622 Self and family

This Plan has full accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's California website at **http://www.ca.kaiserpermanente.org**

Authorized for distribution by the

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73-003

Kaiser Foundation Health Plan, Inc.—California Division

Kaiser Foundation Health Plan, Inc., - California Division consisting of two areas (Northern California Service Area and Southern California Service Area) has entered into one contract (CS1044) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Health Plan, Kaiser Permanente, or the Plan. The Northern California Service Area offices are located at 1950 Franklin, Oakland, California 94612 and the Southern California Service Area offices are located at 393 East Walnut Street, Pasadena, California 91188.

This brochure is **the official statement of benefits on which you can rely.** A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on **page** 30 of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation—sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan and explain the situation. Northern California Service Area members should call 1-800-759-0584 and Southern California Service Area members should call 1-800-464-4000.
- If the matter is not resolved after speaking to your Plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 18. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See “If you are hospitalized” on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The **benefits** in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new **rates** are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.

- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

  Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

  You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

  Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800-638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. See page 23 for information on the Medicare prepaid plan offered by this Plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements

Separating employees—Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children—You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses—You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available—or chosen—when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of creditable coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Facts about this Plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays them directly for their services. Benefits are available **only** from Plan providers except during a medical emergency, or for covered follow-up and continuing care services. **Members are encouraged to select a personal doctor from among Plan primary care doctors.** Services of a specialty care doctor can only be received by referral from the selected primary care doctor. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at (800) 464-4000 or you may write the Carrier at Kaiser Foundation Health Plan, Inc., P.O. Box 23059, San Diego, CA 92193-3059. You may also contact the Plan at its California website at http://www.ca.kaiserpermanente.org or by email at Callcenter.webmail@cal.kaiperm.org.

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Who provides care to Plan members?

Kaiser Permanente offers comprehensive affordable health care coverage on a prepaid group practice basis. The Northern California Service Area has 30 Plan facilities conveniently located throughout the San Francisco Bay, Sacramento, Stockton and Fresno areas. These facilities include Medical Centers with full hospital facilities and Plan medical offices. The Southern California Service Area has 10 major medical centers and more than 90 medical offices conveniently located throughout the Southern California area. Care must be received at these facilities. Health Plan contracts with The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and independent multi-specialty groups of physicians to provide or arrange all necessary physician care for Plan members. Medical care is provided through doctors, nurse practitioners and other skilled medical personnel working as medical teams at Kaiser Permanente facilities. Specialists in most major specialties are available as part of the medical teams for consultation and treatment. Other necessary medical care, such as physical therapy and laboratory and X-ray services, is also available at Kaiser Permanente facilities. Plan doctors also arrange any necessary specialty care. Hospital care is available upon referral by a Plan doctor.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. Primary care doctors include internists, family practitioners, gynecologists and pediatricians. It is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a referral by your primary care doctor; except for covered follow-up and continuing care, and care received from other Kaiser Permanente Plans.

Choosing your doctor

The Plan's facilities directory lists the Plan's facilities and services, with the locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling our Member Services Call Center at 1-800-464-4000; you can also find out if your doctor participates with this Plan by calling the same number. If you are interested in receiving care from a specific provider, call the provider to verify that he or she still participates with the Plan and is accepting new patients. **Important note: When you enroll in this Plan, services (except for emergency and covered travel benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.**

If you are receiving services from a doctor who terminates his or her association with the Plan, the Plan will provide payment for covered services until the Plan can make reasonable and medically appropriate provisions for the assumption of such services by another Plan doctor.

Referrals for specialty care

Except in a medical emergency, for covered follow-up and continuing care services, and for certain specialty care as identified in the Plan's Health Care Directories, you must contact your primary care doctor for a referral before seeing any other doctor or obtaining specialty services. Referral to a specialist is given at the primary care doctor's discretion; if specialists or consultants are required beyond those who are Plan doctors, the primary care doctor will make arrangements for appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation. On referrals, the primary care doctor will give specific instructions to the consultant as to what services are authorized. If additional services or visits are suggested by the consultant, you must first check with your primary care doctor. Do not go to the specialist unless your primary care doctor has arranged for and the Plan has issued an authorization for the referral in advance.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your Plan that allows an adequate number of direct access visits with that specialist. The treatment plan will permit you to visit your specialist without the need to obtain further referrals.

For new members

If you are already under the care of a specialist who is a Plan doctor, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan.

If you are selecting a new primary care doctor and want to continue with this specialist, you must schedule an appointment so that the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach $1,500 per Self Only enrollment or $3,000 per Self and Family enrollment. This copayment maximum does not include costs of prescription drugs, contraceptive devices, cosmetic services, chiropractic services, the $25 charges paid for follow-up or continuing care and all mental conditions services except the first 20 outpatient visits.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

Deductible carryover

If you changed to this Plan during **open season** from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Experimental/ investigational determinations

A service is investigational if it is: (1) not approved by the FDA; or (2) the subject of a new drug or new device application on file with the FDA; or (3) 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) provided pursuant to a written protocol that evaluates the service's safety, toxicity, or efficacy; or (5) subject to the approval or review of an Institutional Review Board; or (6) provided pursuant to informed consent documents that describe the service as experimental or investigational. The Plan and its Medical Group carefully evaluate if a particular therapy is either proven to be safe and effective or offers a degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical literature.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's Service areas

The Service Areas for this Plan, where Plan providers and facilities are located, is described **below**. You must live or work in the Service Area to enroll in this Plan.

Northern California Service Area:

The following Northern California counties in the San Francisco Bay, Sacramento, Stockton, and Fresno areas are within the Service Areas:

- Alameda
- Contra Costa
- Marin
- Sacramento
- San Francisco
- San Joaquin
- San Mateo
- Solano
- Stanislaus

Portions of the counties, as indicated by the zip codes below, are in the Service Areas:

Amador County
95640
95669

El Dorado County
95613-14
95619
95623
95633-35
95643
95651
95664
95667
95672
95682
95762

Fresno County
93242
93602
93606-07
93609
93611-13
93616
93624-27
93630-31
93646
93648-52
93654
93656-57
93660
93662
93667-68
93675
93700-94
93844
93888

Kings County
93230-32

Madera County
93601
93604
93614
93637-39
93643-45
93653
93669

Mariposa County
93623

Napa County
94508
94515
94558-59
94562
94567
94573-74
94576
94581
94599

Placer County
95602-04
95648
95650
95658
95661
95663
95677-78
95681
95703
95722
95736
95746-47
95765

Santa Clara County
94022-24
94035
94039-43
94086-91
94301-99
95002
95008-09
95011
95013-16
95020-21
95026
95030-33
95035-38
95042
95044
95046
95050-57
95070-71
95101-99

Sonoma County
94922-23
94926-28
94931
94951-55
94972
94975
94999
95401-09
95416
95419
95421
95425
95430-31
95433
95436
95439
95441-42
95444
95446
95448
95450
95452
95462
95465
95471-73
95476
95486-87
95492

Sutter County
95622
95659
95668
95674
95676

Tulare County
93618
93666
93673

Yolo County
95605
95607
95612
95616-18
95645
95691
95694-95
95697-98
95776
95798-99

Yuba County
95692
95903
95961

Southern California and Bakersfield Service Areas:

90000-099	92007-09	92276	92570-72	93250-52
90100-199	92014	92282	92581-87	93261
90200-299	92018-27	92292	92595-96	93263
90300-399	92029-30	92305	92599	93268
90400-499	92033	92307-08	92600-699	93276
90500-599	92037-40	92313-18	92700-799	93280
90600-699	92046	92320-22	92800-899	93285
90700-799	92049	92324-26	93000-009	93287
(except 90704)	92051-58	92329	93010-12	93301-09
90800-899	92064-65	92333-37	93015-16	93311-13
91000-099	92067-69	92339-41	93020-21	93380-90
91100-199	92071-72	92345-46	93022	93399
91200-299	92074-75	92350	93030-35	93501-02
91300-399	92079	92352	93040	93504-05
91400-499	92082-85	92354	93041-44	93510
91500-599	92090-93	92357-59	93060-61	93518-19
91600-699	92096	92369	93062-66	93531-32
91700-799	92100-199	92371-78	93093	93534-36
91800-899	92201-03	92382	93099	93539
91901-03	92210-11	92385-86	93203	93543-44
91808-17	92220	92391-94	93205-06	93550-53
91921	92223	92397	93215-17	93560
91931-33	92230	92399	93220	93561
91935	92234-36	92400-499	93222	93563
91941-47	92240-41	92500-532	93224	93581-82
91950-51	92253	92543-46	93225	93584
91962-63	92255	92548	93226	93586
91976-80	92258	92551-57	93238	93590-91
91990-91	92260-64	92562-64	93240-41	93599
91994	92270	92567	93243	

Benefits for care outside the service area are limited to emergency services, covered follow-up and continuing care services, and services received from other Kaiser Permanente plans, as described on page 18.

If you or a covered family member travels frequently or lives away from home part of the year, you should be aware that benefits for care outside the service area are restricted to emergency care, covered follow-up and continuing care services, and care received at Kaiser Permanente facilities in other Kaiser Permanente Service Areas. The service area is the area within which the Plan's providers are most accessible. For this Plan, the service areas are the same as the enrollment area listed on page 10 of this brochure (the area in which you must live or work to enroll in this Plan).

If you or a covered family member move outside the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan**. This brochure is **the official statement of benefits on which you can rely.**

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Arbitration of claims

Any claim for damages for personal injury, mental disturbance or wrongful death arising out of the rendition of or failure to render services under this contract must be submitted to binding arbitration.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, follow-up or continuing care, unless you use Plan providers. You must tell your Plan that you or your family member is eligible for Medicare. Generally, this is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given to this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary care provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

General Limitations *continued*

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency)

DVA facilities, DOD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third-party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition. The following are excluded:**

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies and services received under the Travel Benefit (see Emergency Benefits and Benefits Available Away From Home);
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and 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.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office and outpatient surgery visits; you pay a $5 per office visit copayment; but nothing for ultraviolet light therapy treatment visits, laboratory test and X-rays. Within the service area, the home health services benefit is provided as listed below and if in the judgement of the Plan doctor such care is necessary and appropriate; you pay nothing for home health visits by nurses and health aides.

The following services are included and are subject to the office visit copayment unless stated otherwise:

- Preventive care, including well-baby care and periodic check-ups. All scheduled preventive Pediatric Department office visits for children from birth until age two will be provided at no charge.
- Mammograms—for women age 35 through 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years at no charge. In addition to routine screening, mammograms are covered when prescribed by the doctor to diagnose or treat your illness.
- Routine immunizations and boosters at no charge
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays at no charge
- Complete obstetrical (maternity) care for all covered females including prenatal, delivery and postnatal care by a Plan doctor. Following confirmation of pregnancy, all medically necessary Obstetrical Department prenatal visits and the first post-partum visit will be provided at no charge. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn during the covered portion of the mother's confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of a newborn who requires definitive treatment will be covered only if the newborn is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials (such as allergy serum) will be provided at no charge
- Blood and blood products and the administration of blood (no charge)
- The insertion of internal prosthetic devices such as pacemakers and artificial joints
- Cornea, heart, heart-lung, kidney, pancreas-kidney, simultaneous pancreas-kidney, liver and lung (single or double) transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic on non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphona, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Transplants are covered when approved by the Medical Group. Related medical and hospital expenses of the donor are covered.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure
- Dialysis (office visit charges will be waived if you enroll in Medicare Part B and assign your Medicare benefits to the Plan)

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

- Chemotherapy and critical adjuncts, respiratory therapy and radiation therapy at no charge
- Cardiac rehabilitation following a heart transplant, bypass surgery or myocardial infarction
- Surgical treatment of morbid obesity
- For members confined to their homes within the service area, home health services of doctors, nurses and health aids and physical, speech and occupational therapists, including intravenous fluids and medications, at no charge, when prescribed and directed by the Plans' Home Health Committee, which will periodically review the program for continuing appropriateness and need.
- Visits to receive injections
- Medical management of mental health conditions, including drug therapy evaluation and maintenance
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you, except as noted.

If a member does not pay the applicable office visit charge at the time the services are provided, the member will be billed for the service. The Plan shall collect an administrative charge of $5 for every service for which payment was not made at the time the service was received. These charges will be included in the bill.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an outpatient or inpatient basis if significant improvement can be expected within two months; **you pay $5 per outpatient session and nothing for an inpatient session**. Speech therapy is limited to treatment of certain speech impairments of organic origin. 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. You may receive outpatient or inpatient therapy as part of a specialized therapy program in a specialized rehabilitation facility for up to two months per condition; **you pay nothing**.

Durable medical equipment (DME), when intended to be used repeatedly and in the home is covered. Coverage is limited to the standard item of DME in accord with the Plan's formulary guidelines, that adequately meets the medical needs of the member. **You pay nothing**. The following items are not covered: comfort and convenience equipment; exercise and hygiene equipment; disposable supplies (except ostomy and urological supplies); electronic monitors of the function of the heart or lungs (except apnea monitors for newborns), and devices to perform medical test on blood or other bodily substances or excretions (except blood glucose monitors for diabetics); dental appliances; experimental or research equipment; devices not medical in nature such as sauna baths and elevators; and modifications to the home or auto; chiropractic appliances, except as specifically provided in the chiropractic benefit.

External prosthetic and orthotic devices and braces are covered. **You pay nothing**. Coverage is provided for those FDA-approved devices which are in general use and are required because of a defect of form or function of a permanently inoperative or malfunctioning body part. Lenses following cataract removal are covered. Foot orthotics are not covered.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Medical and Surgical Benefits *continued*

Chiropractic services are provided through American Specialty Health Plans (ASHP). You will have direct access to a participating ASHP chiropractor without the need to obtain a Plan doctor referral. Participating chiropractors are listed in the ASHP Participating Provider Directory. Specific details of this chiropractic benefit are listed in the ASHP evidence of coverage/disclosure form. You phone the ASHP chiropractor you have selected for an initial examination. After the initial examination and except for chiropractic emergency services, your ASHP chiropractor is responsible to obtain authorization from ASHP for any additional chiropractic services on your behalf. **You pay $15 per office visit**, up to a maximum of 20 visits per calendar year. When necessary and prescribed by an ASHP chiropractor, you may receive up to $50 of chiropractic appliances per calendar year. ASHP will not cover any chiropractic services if you were referred through your Plan doctor.

Diagnosis and treatment of infertility is covered. **You pay $5 per office visit**. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI); **you pay $5 per office visit**; cost of donor sperm and donor eggs and services related to their procurement and storage is not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization, gamete and zygote intrafallopian transfer, are not covered. Infertility services are not available when either member of the family has been voluntarily surgically sterilized. Drugs used for covered infertility treatments are provided under the Prescription Drug Benefit. Drugs related to non-covered infertility treatments are not covered.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance or governmental licensing.
- Reversal of voluntary, surgically induced sterility
- Surgery primarily for cosmetic purposes
- External and internally implanted hearing aids
- Homemaker services
- Long-term rehabilitative therapy
- Transplants not listed as covered
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism.

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay nothing**. **All necessary services are covered,** including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units
- Prescribed drugs and their administration, blood and blood products and the administration of blood, biologicals, supplies, and equipment ordinarily provided or arranged as part of inpatient services

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Hospital/Extended Care Benefits *continued*

Extended care

The Plan provides a comprehensive range of benefits for up to 100 days per benefit period when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate. A benefit period begins when a person enters a hospital or skilled nursing facility and ends when a person has not been a patient in either a hospital or skilled nursing facility for 60 consecutive days. **You pay nothing**. **All necessary services are covered,** including:

- Bed, board and general nursing care
- Prescribed drugs and their administration, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home. **You pay nothing.** Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. **You pay nothing.**

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization may be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 20 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care and care in an intermediate care facility

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Benefits Available Away From Home

Services From Other Kaiser Permanente Plans

When you are outside the service area of this Plan, you may still receive covered health care services. There are two types of coverage provided under your enrollment in this Plan.

When you are 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 and from any Kaiser Permanente provider. (**You pay the charge required by the Plan you visit for services provided to federal enrollees in that Plan's service area.**) If the Kaiser Permanente plan in the area you are visiting has a benefit that is different from the benefits of this Plan, you are not entitled to receive that benefit. Some services covered by this Plan, such as artificial reproductive services and the services of specialized rehabilitation facilities, will not be available in other Kaiser Permanente service areas. If a benefit is limited to a specific number of visits or days, you are entitled to receive only the number of visits or days covered by the plan in which you are enrolled. If you are seeking routine, non-emergency or non-urgent services, you should call the Kaiser Permanente member services department in that service area and request an appointment. You may obtain routine follow-up or continuing care from these Plans, even when you have obtained the original services in the service area of this Plan. If you require emergency services as the result of an unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care.

Benefits Available Away From Home *continued*

At the time you register for services, you will be asked to pay the copayment required under your enrollment in this plan/the local plan.

Benefits Available While You Travel

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 that Kaiser Permanente Plan, please call the Member Services Call Center at 1-800-464-4000.

If you are outside the service area of this Plan by more than 100 miles, or outside the service area of any other Kaiser Permanente Plan, the following health care services will be covered:

Follow-up care—care necessary to complete a course of treatment following receipt of covered out-of-plan emergency care, or emergency care received from Plan facilities, if the care would otherwise be covered and is performed on an outpatient basis. Examples of covered follow-up care include the removal of stitches, a catheter or a cast.

Continuing care—care necessary to continue covered medical services normally obtained at Plan facilities, as long as care for the condition has been received at Plan facilities within the previous 90 days and the services would otherwise be covered. Services must be performed on an outpatient basis. Services include scheduled well-baby care, prenatal visits, medication monitoring, blood pressure monitoring and dialysis treatments. The following services are not covered: hospitalization, infertility treatments, childbirth services, and transplants. Prescription drugs are not covered. However, you may have prescriptions filled by mail through this Plan's Prescription Drug Benefit.

If you have any questions about how to use these benefits, call the Travel Benefit Information Line at 1-800-390-3509. You may obtain the Travel Benefits for Federal Employees brochure by calling this number. You should pay the provider at the time you receive the service. Submit a claim to the Plan for the services on the Plan's Claim for Follow-up/Continuing Care Medical Services Form, with necessary supporting documentation. Submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Submit claims to Kaiser Foundation Health Plan, Inc., Claims Department, P.O. Box 12923, Oakland CA 94604-2923 if you reside in the Northern California service area; or Kaiser Foundation Health Plan, Inc., Claims Department, P.O. Box 7102, Pasadena, CA 91109-9880 if you reside in the Southern California service area. If the services are covered under this Travel Benefit, you will be reimbursed the reasonable charges for the care, up to a maximum of $1200 per calendar year. **You pay $25 for each follow-up or continuing care visit**. This amount will be deducted from the payment the Plan makes to you.

Emergency Benefits

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or 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 the Plan may determine are medical emergencies—what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, call or go for treatment to the nearest Kaiser Permanente Medical Center. Emergency care is available through Kaiser Permanente 24 hours a day, 7 days a week. The location and phone number of your nearest Kaiser Permanente facility may be found in your FEHBP Facilities Guide.

In an extreme emergency, if you are unable to go to a Kaiser Permanente Medical Center, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Kaiser Permanente member so they can notify Kaiser Permanente. You or a family member must notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been notified.

Emergency Benefits

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in a non-Plan facility, Plan doctors will arrange a transfer to a Plan hospital when medically feasible. The Plan pays for any medically necessary transportation.

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.

Plan pays . . .

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay . . .

$25 per hospital emergency room visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the charge is waived.

Emergencies outside the Service Area

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 open 24 hours a day, 7 days a week. You may also obtain information about the location of facilities by calling the Member Services Call Center at 1-800-464-4000.

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in a non-Plan facility, Plan doctors will arrange a transfer to a Plan hospital when medically feasible. The Plan pays for any medically necessary transportation.

Plan pays . . .

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay . . .

$25 per hospital emergency room visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the charge is waived.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctor services
- Ambulance service approved by the Plan

What is not covered

- 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

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. Submit claims to Kaiser Foundation Health Plan, Inc., Claims Department, P.O. Box 12923, Oakland CA 94604-2923 if you reside in the Northern California service area; or Kaiser Foundation Health Plan, Inc., Claims Department, P.O. Box 7102, Pasadena, CA 91109-9880 if you reside in the Southern California service area. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 26.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing; **you pay $5 per visit** (These visits are not charged as mental health outpatient visits.)
- Psychiatric treatment (including individual and group therapy)
- Medical management visits, including drug evaluation and maintenance. **You pay $5 per visit.** (These visits are not charged as mental health outpatient visits.)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 40 outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; **you pay $10** for each covered individual therapy visit, **$5** for each covered group therapy visit—all charges thereafter.

If a member does not pay the applicable office visit charge at the time the services are provided, the member will be billed for the service. The Plan shall collect an administrative charge of $5 for every service for which payment was not made at the time the service was received. These charges will be included in the bill.

Unless an appointment is canceled at least 24 hours in advance, members must pay $20 for a missed individual therapy appointment and $10 for a missed group therapy appointment.

Inpatient care

Up to 45 days of hospitalization each calendar year (less one day for each two sessions of day and night care received, or less one day for each three sessions of care received in an intensive outpatient psychiatric treatment program); **you pay nothing** for the first 45 days—all charges thereafter.

Day and night care

If, in the professional judgment of a Plan doctor, a member would benefit from day care or night care services, up to 90 sessions of such prescribed care are provided without charge each calendar year. However, the number of such sessions is reduced by two for each day of hospitalization for inpatient Mental Conditions services received during the calendar year. Day and night care sessions, of no less than four and no more than 12 hour duration, are provided in a hospital-based or residential program. Such care includes all services of Plan doctors and mental health professionals. In addition, the following services and supplies as prescribed by a Plan doctor are covered: room and board, psychiatric nursing care, group therapy, drugs and medical supplies.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness. In addition, the Plan provides:

Inpatient care

- Short-term recovery services, including counseling and support. **You pay nothing**. In the Southern California service area, up to 60 days per calendar year (maximum of 120 days in any five consecutive calendar years) in a non-medical residential care facility that provides counseling and support services will be provided when prescribed by a Plan doctor; **you** pay $100 per admission.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Mental Conditions/Substance Abuse Benefits *continued*

- Methadone treatment for a pregnant member at licensed treatment centers throughout the pregnancy and for two months after delivery. **You pay nothing**.

Outpatient care

Treatment and counseling, including the services to determine the need for specialized facilities; **you pay $5 per visit** ($2 per group therapy session).

If a member does not pay the applicable office visit charge at the time the services are provided, the member will be billed for the service. The Plan shall collect an administrative charge of $5 for every service for which payment was not made at the time the service was received. These charges will be included in the bill.

What is not covered

- Treatment that is not authorized by a Plan doctor.
- Care in a specialized alcoholism, drug abuse or drug addiction treatment center (except as specifically noted above).

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by Plan doctors or any dentist and obtained at a Plan pharmacy will be dispensed for up to a 90-day supply. **You pay** a $5 copayment per prescription or refill. It may be possible for you to receive refills by mail at no extra charge. Delivery may be made available at an additional charge. Ask for details at a Plan pharmacy.

The Plan uses a formulary to determine which prescribed drugs will be provided to members. If the doctor or dentist specifically prescribes a nonformulary drug, and does not prescribe a substitution, the nonformulary drug will be covered. If you request the nonformulary drug when your doctor or dentist has prescribed a substitution, the nonformuarly drug is not covered. However, you may purchase the nonformulary drug from a Plan pharmacy at the Plan's retail prices.

The following drugs are drugs provided at the **$5 charge** (unless another charge is specifically identified):

- Drugs for which a prescription is required by law
- Oral contraceptive drugs, diaphragms, cervical caps and intrauterine devices
- Implanted time-release drugs. **You pay** a one-time payment equal to the $5 per prescription times one-third the expected number of months the drug will be effective, not to exceed $200. There will be no refund of any portion of these copayments if the implanted time-release medication is removed before the end of its expected life.
- Injectable contraceptives are provided up to a 90-day period of expected effectiveness; **you pay** a one-time copayment of $5 per injection.
- Insulin
- Glucose test strips
- Smoking cessation drugs. Coverage is limited to one course of treatment per calendar year under the following conditions:

  1) the drug is prescribed by a Plan doctor; **and**

  2) the member enrolls in a Plan-approved behavioral intervention program

The Plan provides the following at **no charge:**

- Disposable needles and syringes needed for injecting covered prescribed drugs
- Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU)
- Immunosuppressant drugs required after a covered transplant
- Ostomy supplies
- Intravenous fluids and medications for home use
- Enteral elemental dietary formulas when used as primary therapy for regional enteritis
- Chemotherapy drugs

Limited Benefits

Drugs to treat sexual dysfunction have dispensing limitations. You pay 50% of charges. Contact the Plan for details.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Drugs related to non-covered services, including infertility services

Other Benefits

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, eye refractions (to provide a written lens prescription for eyeglasses, but not for contact lenses) may be obtained from Plan providers. **You pay** a $5 copayment per visit.

What is not covered

- Corrective lenses or frames
- Examinations for contact lenses or the fitting of contact lenses
- Eye exercises

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Special Benefits for Medicare Eligible Enrollees

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

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

Like your FEHBP enrollment in this Plan, you are required to obtain your services from this Plan's doctors and providers, except for emergencies and out-of-area urgent care. The rules regarding enrollment in Kaiser Permanente Senior Advantage are fully explained in Disclosure Form/Evidence of Coverage for Senior Advantage Federal Members. For a copy of these rules, please contact Member Services Call Center at 1-800-464-4000.

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

If you choose to enroll in Senior Advantage, you will be responsible for paying the Part B premium. You must make an affirmative enrollment in Senior Advantage. Information regarding enrollment and disenrollment rules may be found in the Evidence of Coverage for Senior Advantage Federal Members. You will also continue to pay the employee share of the FEHBP premium.

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the Disclosure Form/FEHB premium and any charges for these services do not count toward any FEHB deductibles, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Eyewear discount

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

Limitations & Exclusions

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

Expanded dental benefits

Kaiser Permanente is pleased to offer Federal employees, retirees and dependents a choice of dental coverages to supplement your medical plan. These coverages are through Delta Dental Plan of California.

OPTION I /DeltaCare:

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

OPTION II /DeltaAdapTable:

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

Monthly premium:*

	OPTION I/Delta Care:	OPTION II/DeltaAdapTable:
Self Only	$ 7.63	$19.90
Self & One Party	$12.76	$35.40
Self & Two or More	$19.35	$53.20

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

How to enroll

Please use the enclosed postage paid card to send in your application. If you would like more information on DeltaAdapTable, please call 1-800-933-9312. A Delta Dental representative will be able to assist you Monday through Friday, 8:15 a.m.–4:30 p.m. For information on DeltaCare, please call 1-800-422-4234, where a Delta Dental representative will be able to assist you Monday through Friday, 6 a.m.–6 p.m.

Payments for the DeltaAdapTable or DeltaCare programs will be made by automatic withdrawal from your checking, savings, or credit union account.

*These rates are effective January 1, 1999 through December 31, 1999.

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

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Member Services Office at the number listed in the facilities directory or write to Kaiser Foundation Health Plan Inc., Northern California Service Area at 1950 Franklin, Oakland, California 94612 or Southern California Service Area at 393 East Walnut Street, Pasadena, California 91188. You may also contact the Plan at its California website at **http://www.ca.kaiserpermanente.org.**

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, DC 20044.

You (or a person acting on you behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement—If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

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How Kaiser Foundation Health Plan, Inc., California Division Changes January 1999

Do not rely on this page; it is not an official statement of benefits.

Program-wide changes:

Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.

- **Women may see their Plan gynecologist as a primary care doctor (See page 7).**
- **If you have a chronic, complex, or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist, without the need to obtain further referrals (See page 8 for details).**
- **A medical emergency is defined as 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 (See page 18).**
- **The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 40 outpatient Mental Conditions visit limit.**

Changes to this Plan:

- A charge of $5 will be added to any office visit charge that is not paid at the time the member receives services (See page 15).
- A travel benefit that covers follow-up and continuing care has been added up to a maximum of $1,200 per calendar year (See page 18).
- Drugs to treat sexual dysfunction are covered under this Plan's Prescription Drug Benefit (See page 22).
- The copayment for group therapy visits has decreased from $2.50 to $2.00 (See page 21).
- Dialysis services will be provided at the office visit charge of $5. However, if a member is covered by Part B of Medicare and assigns to the Plan the right to collect payment from medicare for these services, the office visit charge will be waived.
- Federal members with Part A and B of Medicare may enroll in this Plan's Senior Advantage Program, also known as Medicare risk or Medicare + Choice (See page 23).

Summary of Benefits for Kaiser Foundation Health Plan, Inc., California Division—1999

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, FOLLOW-UP AND CONTINUING CARE AND CARE RECEIVED FROM OTHER KAISER PERMANENTE PLANS, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing	16
	Extended care	All necessary services, up to 100 days per benefit period. You pay nothing	17
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 45 days of inpatient care per year. You pay nothing	20
	Substance abuse	Covered under Mental Conditions Benefit	20
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay $5 copayment per office visit and outpatient surgery visit	14
	Home health care	All necessary visits by nurses and health aides. You pay nothing	14
	Mental conditions	Up to 40 outpatient visits per calendar year. You pay a $10 copayment per individual visit; $5 per group therapy session	20
	Substance abuse	Treatment and counseling visits. You pay a $5 copayment per individual visit; $2.00 per group therapy session. Mental conditions services are also covered as shown	21
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay applicable Plan copayment and all charges for non-covered benefits	18
Prescription drugs		Drugs prescribed by your doctor or dentist and obtained at a Plan pharmacy. You pay $5 per prescription unit or refill	21
Dental care		No current benefit	
Vision care		Refractions. You pay $5 copayment per visit	23
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,500 per Self Only or $3,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copayment maximum does not include prescription drugs and other services listed on page	8

1999 Rate Information for Kaiser Foundation Health Plan, Inc., California Division

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

Postal rates apply to most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	591	$60.23	$20.07	$130.49	$43.49	$71.27	$9.03
Self and Family	592	$143.76	$47.92	$311.48	$103.83	$170.12	$21.56
Self Only	621	$66.53	$22.17	$144.14	$48.04	$78.72	$9.98
Self and Family	622	$153.77	$51.25	$333.16	$111.05	$181.96	$23.06