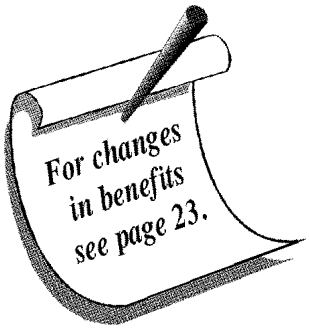
KAISER PERMANENTE

Kaiser Permanente 1999

A Health Maintenance Organization



Serving: Albany, New York and surrounding counties;
Cooperstown, New York and surrounding counties;
Hudson Valley Region of New York; and Vermont:

Enrollment in this Plan is limited; see page 8 for requirements.

Region I includes the Albany and Cooperstown, New York area

Enrollment code:
PW1 Self Only
PW2 Self and Family

Region II includes the Hudson Valley of New York area

Enrollment code:
QB1 Self Only
QB2 Self and Family

Region III includes the Vermont area

Enrollment code:
8M1 Self Only
8M2 Self and Family

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

Authorized for distribution by the:

United States Office of Personnel Management

FEHB
Federal Employees Health Benefits Program

R173-053

Kaiser Permanente

Community Health Plan, d.b.a. Kaiser Permanente, 1 CHP Plaza, Latham, NY, 12110, has entered into a contract (CS 1760) 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 or Kaiser Permanente.

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 23 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 at Utilization Review (518) 783-1864 and explain the situation.
- 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 15. 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 3.

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.

General Information *continued*

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 re-enroll 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 20 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.

General Information *continued*

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 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. Members are required to select a personal doctor from among participating 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 places great emphasis on 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.

Kaiser Permanente Northeast is a mixed model Health Maintenance Organization. Kaiser Permanente provides you with medical care through a core group of medical providers and affiliated specialists. Kaiser Permanente medical offices are the location of your doctor's office and support services. Upon joining Kaiser Permanente, you are encouraged to select a doctor from those available at the medical office most convenient for you to use. Kaiser Permanente offers a choice of over 5,000 primary care providers and specialists who may be either in private practice or staffed at one of our medical offices. Upon joining Kaiser Permanente, you are encouraged to select a doctor from those available at the medical office or at an affiliate practice most convenient for you to use. Each family member would choose their own personal doctor for their health care. When the services of a specialty not represented by the Plan are required, you will be referred by your Kaiser Permanente doctor to specialists or facilities in that geographic area, and all such referrals are covered.

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 1-800-638-0668 or you may write the Carrier at Kaiser Permanente, 1 CHP Plaza, Latham, New York 12210. You may also contact the Carrier by fax at (518) 785-2741 or at its website at http://www.kaiserpermanente.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 non compliant, 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?

Role of the 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 you have been a referred by your primary care doctor, except for covered follow-up and continuing care and care received from other Kaiser Permanente Plans.

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, and internists) with their locations and phone numbers and notes whether or not the Plan is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Enrollment Department at:

New York	(518) 783-1864 (Capital Area); (518) 562-0151 (Plattsburgh); (607) 547-9244 (Cooperstown Area); (518) 798-8214 (Glens Falls); (914) 471-2368 (Hudson Valley Region)
Vermont	(802) 447-2343 (Bennington); (802) 878-2334 (Burlington)

You can also find out if your doctor participates with the Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, 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 emergency) are provided through the Plan's delivery system, but the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.

If you enroll, you will be asked to let the Plan know which primary care doctor(s) you've selected for you and each member of your family by sending a selection form to the Plan. If you need help choosing a doctor, call the Plan. Members may change their doctor selection by notifying the Plan 30 days in advance.

If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

Referrals for specialty care

Except in a medical emergency or when a primary care doctor has designated another doctor to see patients when he or she is unavailable, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. Do not go to the specialist for second visit unless your primary care doctor has arranged for, and the Plan has issued an authorization for, the referral in advance. If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

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 health 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.

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor must obtain the Plan's determination of medical necessity before you may be hospitalized, referred for specialty care, receive a prescription for a nonformulary drug or obtain follow-up care from a specialist.

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain referral from a Plan primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you to this specialist is now your Plan primary care doctor, you need only to call to explain that you are now a Plan member and ask that you be referred for your next appointment.

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 Deductible carryover

Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for a few benefits.

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 experimental or investigational if it is: (1) not approved by the FDA; (2) the subject of a new drug or new device application on file with 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 standard 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 which may be recommended by Plan providers.

The Plan's service areas

The service area for this Plan, where Plan providers and facilities are located, is described below: You must live or work inside the service area or live in the geographic area described below.

The service area for this Plan includes the following areas:

Region I	**Region II**	**Region III**
New York	**Hudson Valley (NY)**	**Vermont**
Albany County	Dutchess County	Addison County
Broome County	Orange County	Bennington County
Chenango County	Putnam County	Caledonia County
Clinton County	Ulster County	Chittenden County
Delaware County		Essex County
Essex County		Franklin County
Fulton County		Grand Isle
Greene County		Lamoille County
Hamilton County		Orange County
Madison County		Orleans County
Montgomery County		Rutland County
Oneida County		Washington County
Otsego County		Windham County
Rensselaer County		Windsor County
Saratoga County		
Schenectady County		
Schoharie County		
Sullivan County		
Tioga County		
Warren County		
Washington County		

Benefits for care outside the service area are limited to emergency services, as described on page 15.

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.

This Plan has different enrollment codes and corresponding rates for Region I, Region II and Region III as described on the front cover of this brochure. If you are enrolling in this Plan for the first time, you must select the enrollment code that reflects the area that you live in, and you will be restricted to using Plan doctors and facilities in that area only.

Facts about this Plan *continued*

Reciprocity

The Plan has a reciprocal agreement with GHAA member organizations to cover ambulatory (outpatient) medical care for members traveling outside the service area. The services include illness of an acute or serious nature that cannot be postponed until the member returns to the home plan. The services do not include routine and specialty care and is limited to areas where there is a participating health maintenance organization. Members must arrange for the reciprocal services through their Kaiser Permanente doctor prior to obtaining the services.

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.

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 continuous care, unless you use Plan providers. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that 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 (l) 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 no-fault automobile insurance, including no-fault, the no-fault 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 this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

General Limitations *continued*

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 provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

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 dentists. This includes all necessary office visits; **you pay a $10** office visit copay, but no additional copay for laboratory tests and X-rays. Within the Service Area, house calls will be provided if in the judgement of the Plan doctor such care is necessary and appropriate; **you pay a $10** house call copay for a doctor's visit, **a $10** copay for visits by nurses and health aides.

The following services are included:

- Preventive care and periodic check-ups
- Well baby care visits up to age 19; **you pay nothing**
- Mammograms are covered as follows: 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. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Visits to Primary Care doctors, non-physicians and consultations with specialists.
- Diagnostic procedures, such as laboratory tests and X-rays; **you pay nothing**
- Complete obstetrical (maternity) care for covered females, including all prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean 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 child during the covered portion of the mother's hospital 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 infant 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 materials)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Cornea, heart, heart-lung, kidney, simultaneous pancreas-kidney, liver and lung (single and 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 or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- 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)
- Chemotherapy, radiation therapy, and respiratory therapy
- Surgical treatment of morbid obesity
- Orthopedic devices, such as braces
- Prosthetic devices, such as artificial limb and lenses following cataract removal
- Durable medical equipment, such as wheelchairs and hospital beds

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

- Home health services of doctors, nurses, and health aides, including intravenous fluids and medications, when prescribed and directed by your Plan doctor, who will periodically review the program for continuing appropriateness and need.
- Services of physicians and other health professionals in the hospital or extended care facility
- Medical management of mental health conditions, including drug therapy evaluation and maintenance.
- Visits to receive injections
- Hearing tests and hearing aides
- Cardiac rehabilitation following heart transplant, bypass surgery or a myocardial infarction
- Office visit and related diagnostic tests in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer or any recommendation of a course of treatment for cancer. The specialist rendering the second medical opinion must be a Kaiser Permanente affiliated specialist to whom the member received a referral from a Plan primary care doctor, unless the member receives an approved referral to a non-participating specialist from a Plan primary care doctor. Any further care rendered beyond, or as a result of, the second opinion must be arranged by Plan doctors.
- If you do not pay any of the charges required for services at the time you receive the services, you will be billed for those charges. You will also be required to pay an administrative charge of $10 for each service for which a bill is sent.

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 no limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or the intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition that has resulted from functional defect or from an 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. In the case of reconstructive surgery on a breast on which a mastectomy has been performed, coverage will also be provided for New York residents, for reconstructive surgical procedures on the other non-diseased breast to produce a symmetrical appearance.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months. **You pay nothing per inpatient session and $10 per outpatient session.** Speech therapy is limited to treatment of certain speech impairments of organic orgin. Occupational therapy is limited to services that assist the member to achieve self-care and improved functioning in other activities of daily living.

Diagnosis and treatment of infertility is covered. **You pay 50%** of covered charges. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI)); you pay 50% of covered charges. 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 transfers and embryo transfers 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 at 50% of the over the counter charge to members who do not have a prescription drug benefit.] Drugs related to non-covered infertility treatments are not covered.

Chiropractic services (defined as manual manipulation of the spine to correct nerve interference caused by distortion, misalignment or subluxation of the vertebral column) are covered. All other forms of chiropractic services are excluded.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Medical and Surgical Benefits *continued*

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, licensing, governmental, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Internally implanted hearing aids
- Homemaker services
- Blood and blood derivatives not replaced by the member
- Long-term rehabilitative therapy
- Transplants not listed as covered
- Any eye surgery solely for the purpose of connecting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hypezopia) and astigmatism.

Hospital/Extended Care Benefits

What is covered

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:

Hospital care

- 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

Extended care

The Plan provides a comprehensive range of benefits with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **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 or Plan approved hospice facility. 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 17 for non-medical substance abuse benefits.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Hospital/Extended Care Benefits *continued*

What is not covered

- Personal comfort items, such as telephone and television
- Blood and blood derivatives not replaced by the member
- Custodial care and care in an intermediate care facility

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 Kaiser Permanente medical offices and medical centers and from Kaiser Permanente providers. (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 days or visits, you are entitled to receive only the number of days or visits covered by the Plan in which you are enrolled.

If you are seeking routine, non-emergent or non-urgent services, you should call the Kaiser Permanente member services department in that 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 hospital to receive care.

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.

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 Customer Service Department at 1-800-638-0668, extension 47800.

Benefits Available While You Travel

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 this Plan's Claim for Follow-up/Continuing Care Medical 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 Permanente, Claims Department, PO Box 15109, Albany, New York 12212-5109. If the services are covered under this Travel Benefit, you will be reimbursed the reasonable charges for the care, up to a maximum of $1,200 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.

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Emergency Benefits

What is a medical emergency?

A medical emergency is an injury or 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, please call your primary care doctor. If you are in an emergency situation and are unable to contact your primary care doctor, 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 Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours, unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

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 or **$10** per visit for emergency care services provided at a Kaiser Permanente Medical Office which are covered benefits of this Plan. If the emergency results in admission to a hospital, **you pay nothing.**

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."You may also call the Customer Service Department at the following phone number: 1-800-638-0668, extension 47800. This number is open 24 hours a day, 7 days a week.

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 a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

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 or **$10** per hospital office visit or urgent care center visit for emergency services that are covered by this Plan. If the emergency results in admission to a hospital, **you pay nothing.**

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 doctors'services
- Ambulance service approved by the Plan

Emergency Benefits *continued*

What is not covered

- Elective care or nonemergency 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

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 Permanente, Claims Department, PO Box 15109, Albany, New York 12212-5109. 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 22.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, this 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
- Psychiatric treatment (including individual and group therapy)
- Medical management visits, including drug evaluation and maintenance. You pay $10 per visit. (These visits are not charged as mental health outpatient visits.)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 25 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; **you pay $10** per visit.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay nothing** for 30 days - all charges thereafter.

If you do not pay any of the charges required for services at the time you receive the services, you will be billed for those charges. You will also be required to pay an administrative charge of $10 for each service for which a bill is sent.

What is not covered

- Care for psychiatric conditions which 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 when 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, nonpsychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness. In addition, the Plan provides:

Outpatient care

All necessary outpatient visits to Plan providers for treatment each calendar year; **you pay $10** for each covered visit.

Inpatient care

Services for the psychiatric aspects are provided in conjunction with the inpatient mental conditions benefit shown above. The mental conditions day limit applies.

If you do not pay any of the charges required for services at the time you receive the services, you will be billed for those charges. You will also be required to pay an administrative charge of $10 for each service for which a bill is sent.

What is not covered

- Treatment that is not authorized by a Plan doctor
- Substance abuse treatment on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate

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Prescription Drug Benefits

What is covered

Prescription drugs prescribed by Plan doctors or dentists and obtained at a Plan pharmacy will be dispensed for up to a 34 day supply. **You pay 20% of the cost 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 prescrived a substitution, the nonformulary drug is not covered. However, you may purchase the nonformulary drug from a Plan pharmacy at prices charged to members for non-covered drugs.

The following drugs are provided **(you pay 20% of the cost)**:

- Drugs for which a prescription is required by law
- Oral and injectable contraceptive drugs
- Insulin
- Glucose test strips
- Disposable needles and syringes needed for injecting covered prescribed medication; you pay nothing
- Medically necessary enteral formulas proven to be effective as a disease specific treatment for individuals who are or will become malnourished or suffer from disorders which, if untreated, will cause disability, retardation or death
- Modified solid food products for the treatment of certain inherited diseases of amino acid or organic acid metabolism to a maximum of $2,500 per person per calendar year
- Intravenous fluids and medication for home use are covered under Medical and Surgical Benefits.

Limited Benefits

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

If you do not pay any of the charges required for services at the time you receive the services, you will be billed for those charges. You will also be required to pay an administrative charge of $10 for each service for which a bill is sent.

What is not covered

- Drugs available without a prescription or for which there is a non-prescription 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, except as specifically noted
- Medical supplies such as dressings and antiseptics
- Contraceptive devices
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medication, including nicotine patches
- Implanted time-release medications, including Norplant
- Fertility drugs
- Drugs for non-covered services

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Other Benefits

Dental care

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury. **You pay $10** per visit.

What is not covered

- Other dental services not shown as covered

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (which include the written lens prescription for eyeglasses) may be obtained from Plan providers. **You pay $10** per visit.

What is not covered

- Corrective eye glasses and frames or contact lenses (including the fitting of the lenses)
- Eye exercises

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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 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 procedures.

Medicare prepaid plan enrollment

Medicare prepaid plan enrollment - This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 3, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-638-0668 for information on the Medicare prepaid plan and the cost of that enrollment.

Expanded dental benefits

Kaiser Permanente provides you with a direct pay dental care plan which allows you to obtain dental services with limited copayments, no deductibles and no lifetime limit.

This special open enrollment for Kaiser Permanente's Dental Care Plan is available to those Kaiser Permanente members already enrolled or enrolling for January, 1999 in Kaiser Permanente's Medical Care Plan. In order to join Kaiser Permanente's Direct Pay Dental Plan you must be a member of Kaiser Permanente's Medical Care Plan as of January, 1999.

Coverage

Kaiser Permanente will provide you, through its dentists, the following care with the copayments due at the time of service:

- Preventive care: cleanings, topical fluoride, oral exam and x-rays as needed (2 visits per calendar year) $2 per visit
- Fillings - you pay 20% of the cost
- Endodontics - root canal treatment - you pay 20% of the cost
- Oral surgery - extraction and wisdom tooth removal - you pay 20% of the cost
- Periodontics - you pay 50% of the cost
- Prosthetics - crowns, bridges and dentures (following a one-year waiting period for new members) - you pay 50% of the cost

Eligibility

You may enroll only for the same coverage as you have under your Kaiser Permanente Medical Care plan, Self Only coverage, or Self and Family coverage which includes you, your spouse and unmarried dependent children to age 22.

Enrollment in the Kaiser Permanente Dental Care Plan is separate from your Kaiser Permanente Medical Plan enrollment and it is your personal choice. You do not have to enroll in the Dental Plan if you take the Medical Plan. However, you must be enrolled in the Medical Plan to take the Kaiser Permanente Dental Care Plan.

Premium

Please contact your regional Enrollment Department for your exact bimonthly premium. The telephone numbers are on page 6 of this brochure.

How to enroll

Contact the Plan's enrollment department for an application for Kaiser Permanente's direct pay dental plan (see page 6 for the local phone numbers).

Deadline

The deadline for the Direct Pay Dental application and bimonthly payment is December 16, 1998. This deadline applies even if you are a new medical member to Kaiser Permanente in 1999.

Smoking cessation benefit

A smoking cessation benefit is available through the Plan. For information, contact the Kaiser Permanente center for health resources at 1-800-638-0668, ext. 36555.

Expanded vision care

Kaiser Permanente optical shops and vision providers offer discounted costs to members for eye exams and eyewear. Please refer to the Kaiser Permanente supplemental brochure for a provider listing.

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 Customer Service Department at (518) 783-1864 (TDY capability available for the hearing impaired at this number) or you may write the Plan at 1 CHP Plaza, Latham, New York 12110. You may also contact the Plan by fax at (518) 785-2741 or at its website at http://www.kaiser-permanente.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, 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 your 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 benefits. 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.

How Kaiser Permanente 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 6.)
- 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 7 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 15.)
- 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 25 outpatient Mental Conditions visit limit.

Changes to this Plan

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 $10 for every service for which payment was not made at the time the service was received. These charges will be included in the bill. (See page 12.)

The Plan has added coverage for a second medical opinion for a positive or negative diagnosis of cancer or course of cancer treatment. (See page 12.)

The Plan has added coverage for certain chiropractic services. (See page 12.)

The reconstructive surgery benefit will now include coverage in the case of a mastectomy, for reconstructive surgery procedures on both the diseased and nondiseased breast to produce a symmetrical appearance. (See page 12.)

Drugs to treat sexual dysfunction are covered under the Prescription Drug Benefit. (See page 18.)

Follow-up medical services and continuing care services will be available while you travel out of the Service Area, subject to a maximum of $1,200 per year. (See page 14.)

The Plan has added coverage for modified solid food products for the treatment of certain diseases of amino or organic acid metabolism to a maximum of $2,500 per calendar year. (See page 18.)

Dialysis services will be provided at the office visit charge of $10. 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. (See page 11.)

The insertion of covered internal prosthetic devices such as pacemakers and artificial joints is covered. (See page 11.)

Summary of Benefits for Kaiser Permanente — 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 with care no dollar or day maximum Includes in-hospital physician 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**	**13**
	Extended care	All necessary services, no dollar or day limit. **You pay nothing.**	**13**
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay nothing**.	**17**
	Substance abuse	Covered under Mental conditions.	**17**
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** a $10 copay per office visit; a $10 copay per house call by a doctor	**11**
	Home health care	All necessary visits by nurses and health aides. **You pay** $10 copay per visit.	**12**
	Mental conditions	Up to 25 outpatient visits per year. **You pay** a $10 copay per visit.	**17**
	Substance abuse	All necessary outpatient visits per year. **You pay** a $10 copay per visit.	**17**
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $25 copay to the hospital for each emergency room visit. You pay in full any charges for services that are not covered by this Plan.	**15**
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a participating pharmacy. **You pay** 20% of the cost per prescription unit or refill.	**18**
Dental care		Accidental injury benefit. **You pay** a $10 copay.	**19**
Vision care		Annually, one refraction and treatment for illness or injury. **You pay** a $10 copay.	**19**
Out-of-pocket maximum		Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for a few benefits.	**7**

1999 Rate Information for Kaiser Permanente

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	PW1	$62.22	$20.74	$134.81	$44.94	$73.63	$9.33
Self and Family	PW2	$158.46	$52.82	$343.33	$114.44	$183.29	$27.99
Self Only	QB1	$65.80	$21.93	$142.56	$47.52	$77.86	$9.87
Self and Family	QB2	$160.39	$67.73	$347.51	$146.75	$183.29	$44.83
Self Only	8M1	$62.97	$20.99	$136.43	$45.48	$74.51	$9.45
Self and Family	8M2	$160.39	$57.91	$347.51	$125.47	$183.29	$35.01