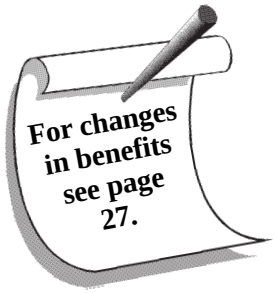
Kaiser Foundation Health Plan of Kansas City, Inc.

1999

A Health Maintenance Organization

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



Serving: Kansas City Metropolitan Area
Kansas and Missouri

Enrollment in this Plan is limited; see page 9 for requirements.

Enrollment code:
HA1 Self Only
HA2 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

Federal Employees Health Benefits Program

RI 73-128

Kaiser Foundation Health Plan of Kansas City, Inc.

The Kaiser Foundation Health Plan of Kansas City, Inc., 10561 Barkley, Overland Park, Kansas 66212 has entered into a contract (CS 1948) 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 Kaiser Permanente or the Plan.

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 27 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 913/642-2662 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 pages 16-17. 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.

General Information *continued*

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. **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 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 (913)642-2662 or 913/642-3696 TDD or you may write the Carrier at Member Services, Kaiser Foundation Health Plan of Kansas City, Inc., 10561 Barkley, Suite 200, Overland Park, Kansas 66212. You may also contact the Plan by fax at (913) 967-4630, or at its national 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 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 health care coverage on a prepaid group practice basis, at six Plan facilities conveniently located throughout the Kansas City metropolitan area, and through referral specialists, hospitals and other providers in the community. Except in an emergency, all care should be received at these facilities. Health Plan contracts with the Permanente Medical Group of Mid-America, P.A., an independent multi-specialty group of physicians, and with Lee's Summit Family Care Center (Lee's Summit, Missouri) and Menorah Health Services (Kansas City, Missouri) to provide or arrange all necessary physician care for Plan members. Medical care is provided through doctors and other skilled medical personnel working as medical teams. Specialists in most major specialties are available as part of the medical teams for consultation and treatment. These doctors are members of American Specialty Boards or are Board Eligible. Plan doctors also arrange for local referral specialists to provide any necessary specialty physician care not directly available from Plan doctors. Other necessary medical services, such as physical therapy and laboratory and X-ray services, are also available at Plan facilities. Hospital care is provided through the Plan at local community hospitals.

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 you have been referred 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 provider directory lists primary care doctors (general practitioners, pediatricians, gynecologists, and internists), with their locations and phone numbers, and notes whether or not the doctor 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 Member Services Representatives at 913/642-2662; you can also find out if your doctor participates with this 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 for emergency 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 enroll, you will be asked to select a primary care doctor for you and each member of your family, and inform your Plan facility of your choice. Members may change their doctor selection by notifying the Plan at any time.

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 or when receiving covered follow-up or continuing care, members must contact their primary care doctor for a referral before seeing any other doctor or obtaining special 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 any authorization for referral in advance.

In the event that you receive a referral for specialty care to a facility outside the service area, the Plan will cover the expenses for travel and lodging for you and one caregiver when that care is received. The cost will be reimbursed on a per diem rate established by the Plan.

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 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 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 a 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 $1,000 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, extended care services, durable medical equipment, external prostheses and braces, the $25 charges paid for follow up or continuing care, dental care services 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.

Facts about this Plan *continued*

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 area

The service area for this Plan, where Plan providers and facilities are located, is below. You must live or work in the service area to enroll in this Plan. Benefits for care outside the service area are limited to services from other Kaiser Permanente Plans, covered follow-up or continuing care or emergency services, as described on pages 16-17.

Services are available in Kansas counties—Johnson, Leavenworth and Wyandotte; and in Missouri counties—Cass, Clay, Jackson and Platte.

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 and care received at Kaiser Permanente facilities in other Kaiser Permanente Regions. The service area is the area within which the Plan's providers are most accessible. For this Plan, the service area is the same as the enrollment area listed on the front cover 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 Plans 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 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 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.

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.

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 office visit copay, but no additional copay for laboratory test and X-rays. You pay a $5 copay for all visits to a non-Plan provider's office. You pay nothing for well child care visits, well woman care visits (routine pap smears and mammograms), prenatal and postnatal care, and personal health appraisals. 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 nothing for a doctor's house call.

- Preventive care, including well-baby care and periodic check-ups (no charge)

- Personal health appraisals

- 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, medically necessary mammograms to diagnose or treat your illness

- Routine immunizations and boosters at no charge

- Consultations with specialists

- Diagnostic procedures, such as laboratory tests and X-rays (no charge)

- Complete obstetrical (maternity) care for covered females, including prenatal, delivery and postnatal care by a Plan doctor 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 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 new born child 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 an infant 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 (including diaphragms)

- Diagnosis and treatment of diseases of the eye

- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)

What is covered
continued

- The insertion of internal prosthetics 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 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)
- Chemotherapy, radiation therapy, and respiratory therapy including colony stimulating drugs as required to maintain the member's general condition during treatment.
- Cardiac rehabilitation—following a heart transplant, bypass surgery or a myocardial infarction, is provided up to the level of rehabilitation where cardiac monitoring is no longer medically necessary.
- Surgical treatment of morbid obesity
- Home health services of nurses, health aides, and wound care supplies, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need.
- Blood and blood products and the administration of blood (no charge).
- Visits to receive injections
- Initial lenses following cataract removal (no charge)
- 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.

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 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, except as covered on page 22.

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.

Limited benefits *continued*

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to thirty visits or two consecutive months per condition, whichever is greater, 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 inpatient therapy as part of a specialized therapy program in a specialized rehabilitation facility for up to two months per condition. **You pay nothing.**

Diagnosis and treatment of infertility is covered; **you pay 50%** of non-member rates. Artificial insemination is covered (including intracervical insemination (ICI), intrauterine insemination (IUI) and intravaginal insemination (IVI); **you pay 50%** of non-member rates per insemination procedure. Cost of donor sperm and donor eggs and services related to their procurement and storage are 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 not covered. Drugs related to non-covered infertility treatments are not covered.

External prosthetic and orthopedic devices and braces—covered only when 1) required to support or correct a defect of form or function or a permanently non-functioning or malfunctioning body part; 2) is primarily used as an alternative to surgery or to speed recovery following surgery; 3) can withstand repeated use; and 4) is in general use before April 1 of the prior year; orthopedic braces for scoliosis; breast prostheses; or as required as a part of acute primary care such as back braces, rib belts, slings and cervical collars. **You pay 20% of member charges.** All other prosthetic or orthopedic devices, including foot orthotics and artificial limbs, 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, attending school or camp, or travel
- 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.
- Chiropractic services
- Durable medical equipment, such as wheel chairs and hospital beds.
- Devices, equipment, supplies and prosthetics related to the treatment of sexual dysfunction

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

Extended care

The Plan provides a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate 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

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 $50.**

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 19 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

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.

Services From Other Kaiser Permanente Plans

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. (Y**ou 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-emergent or non-urgent services, you should call the Kaiser Permanente Member Services Department in that service area and request an appointment. You may obtain routine follow-up or continuing care from these Plans, even when you have obtained the original services in the service area of this Plan. If you require emergency services as the result of an unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care.

At the time you register for services, you will be asked to pay the charges required by the local plan.

If you plan to travel to an area with another Kaiser Permanente Plan and wish to obtain more information about the benefits available to you from that Kaiser Permanente Plan, please call the Member Services Department at (913) 642-2662 or outside the local calling area, call 1-800-726-5247.

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 most 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, as you would an emergency claim. Claims should be submitted to Kaiser Permanente, Member Claims, P.O. Box 378044, Denver Colorado, 80237. 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 an injury or the sudden and unexpected onset of a condition requiring 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 Medical Advice at (913) 385-1155 or outside the local calling area, 1-800-870-5711. Medical Advice is open 24 hours a day, 7 days a week.

Urgent care is available at the Plan's Urgent Care Center located at the Mission Medical Office, 6950 Squibb Road, Suite 200, Shawnee Mission, Kansas; and at Baptist Medical Office, 6675 Holmes Road, Suite 450, Kansas City, Missouri.

In an extreme emergency, if you are unable to contact the Medical Advice line, 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.

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 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 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...

You pay $50 per hospital emergency room visit at a Plan facility or $5 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency room visit 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".

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.

Plan pays...

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

Emergency Benefits *continued*

You pay...

You pay $50 per hospital emergency room visit at a non-Plan facility 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. You pay $50.

What is not covered

- Elective care or non-emergency care, except as specified in Benefits Available Away from Home
- 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. You should submit claims forms to Kaiser Permanente, Member Claims, P.O. Box 378044, Denver, Colorado, 80237. 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 pages 25-26.

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 $20** for each hour of required diagnostic testing)
- 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 visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; you pay nothing for the first visit; **$10 per visit** for individual therapy sessions at visits 2-20; and **$25 per visit** for individual therapy visits 21-40; **you pay $10** for all group therapy visits. (In determining the number of visits, two group therapy visits count as one individual therapy visit; one individual therapy visit counts as two group therapy visits.)

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.

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

For the first 30 days of hospitalization each calendar year, **you pay nothing**; for days 31 through 45, **you pay 50%** of charges. For any additional days, you pay all charges. (The number of covered inpatient days will be reduced by one for every two days of day night care received.)

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 60 sessions of such prescribed care are provided without charge each calendar year. You pay 50% of charges for sessions 61-90. You pay all charges thereafter. 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:

Outpatient care

• All necessary outpatient treatment visits. **You pay nothing** for the first visit; **$20 per visit** for all subsequent visits

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.

Inpatient care

• Up to 30 days of rehabilitative care from Plan providers, if it is determined by a Plan doctor that you are unresponsive to outpatient treatment. **You pay nothing.** For any inpatient days in excess of thirty, you pay all charges.

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
• 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

PRESCRIPTION DRUG BENEFIT

What is covered

Prescription drugs prescribed by Plan or referral doctors, or by general dentists or oral surgeons, and obtained at a Plan pharmacy, will be dispensed for up to a 30 day supply. **You pay $3 per prescription or refill**. Maintenance drugs can be filled in a 60-day supply; **you pay $6.** It may be possible for you to receive refills by mail at no extra 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 physician approves, you will receive the formulary drug. If the physician 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 physician has prescribed a substitution, the nonformuarly 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 drugs provided at the **$3 charge** (unless another charge is specifically identified):

- Drugs for which a prescription is required by law
- Contraceptive diaphragms
- Implanted time-release drugs. You pay a one-time payment equal to the $3 charge per prescription times the expected number of months the drug will be effective, not to exceed $200. The charge will be required, even when the drug is injected in the doctor's office.
- Injectable contraceptives; you pay a one-time charge of $3 per injection times the expected number of months the drug will be effective, not to exceed $200. The charge for the drug applies when the contraceptive drug is injected during a medical office visit.
- Insulin ($3 per vial)
- Glucose test strips

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

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

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
- Drugs related to infertility services
- Smoking cessation drugs, except for nicotine gum

Other Benefits

Dental care

What is covered

The following dental services are covered when provided by participating Plan general dentists. You pay copayments when services are performed by a general dentist. Services of a specialist can only be received by referral from a Plan general dentist. Higher copayments may apply for services received from a specialist; you should contact the Plan for information on these higher copayments. For a complete listing of participating Plan dentists and covered dental services with designated copayments, please call the Plan's Member Services Department at 913/642-2662.

Preventative and Diagnostic Services:

Oral exams, X-rays, prophylaxis (cleaning of teeth) every six months, fluoride treatment, oral hygiene instruction, **you pay** a $5 copayment per member per visit.

GENERAL DENTIST RESTORATIVE SERVICES:	YOU PAY
Amalgam (fillings silver, plastic, or composite)	$ 34- 75
Inlay/onlay	$205-340
Crowns (Stainless Steel, cast or porcelain/metal)	$130-450
PERIODONTIC SERVICES:	
Root Planning (Per Quadrant)	$115
Occlusal Adjustment	$50-230
ENDODONTIC SERVICES:	
Root Canals	$240-420
ORAL SURGERY:	
Simple Extraction	$ 45
Extractions (Each Additional Tooth)	$ 40
Surgical Removal of Erupted Tooth	$ 85
PROSTHETIC SERVICES:	
Dentures (Complete upper or lower)	$450-495
Partial Dentures	$405-505
Denture Relines	$135-170
ORTHODONTIC SERVICES:	
Standard Fully Banded Case (available to members age 19 and under)	$2,750

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 occurring while the member is covered under the Plan. You pay 50% of the first $1,000 in charges per accidental injury and all charges thereafter.

What is not covered

- Prescription drugs prescribed by participating Plan general dentists
- Replacement, due to loss or theft, of denture, bridgework, or any other dental appliances previously provided under this Plan
- Orthodontic work in-progress
- Services of dentists or other practitioners other than participating Plan general dentists or, upon referral, authorized participating specialists, unless authorized by the Plan or required due to a covered emergency

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

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 $5 per visit.

What is not covered

- Eye exercises
- Corrective eyeglasses and frames or contact lenses (including the fitting of the lenses)
- Examination for prescription or contact lenses

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 enrolls 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 the Evidence of Coverage for Senior Advantage Federal members. For a copy of these rules, please contact Member Services at (913) 642-2662 or (800) 726-5247.

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. Refer to Evidence of Coverage for Senior Advantage Federal members for complete enrollment and disenrollment rules. You will also continue to pay the employee share of the FEHBP premium.

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 913/642-2662 or 913/642-3696 TDD or you may write to the Plan at 10561 Barkley, Overland Park, Kansas 66212. You may also contact the Plan by fax at (913) 967-4630, or at its National website at http://www.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 III, 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 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.

How Kaiser Foundation Health Plan of Kansas City, Inc. 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 endangeers your life or could result in serious injury or disability, and requires immediate medical or surgical care (See page 16).
- 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:

The copayment for visits to nurses has increased from $0 to $5 (See page 11).

The copayment for ambulance service approved by the Plan has increased from $0 to $50 (See page 14).

Diagnosis and treatment of infertility will now be covered at 50% of charges (See page 13).

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 15).

Drugs to treat sexual dysfunction are covered under this Plan's Prescription Drug Benefit (See page 20).

Devices, supplies, equipment and prosthetics for the treatment of sexual dysfunction are not covered (see page 13).

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 (See page 12).

The copayments for dental benefits has increased, except for simple extractions, extractions for each tooth and dentures (See page 22).

Federal members with Part A and Part B of Medicare may enroll in this Plan's Senior Advantage program also known as Medicare risk or Medicare + Choice (See page 24).

A charge of $10 will be added to any office visit charge that is not paid at the time the member receives services (See page 12).

Summary of Benefits for Kaiser Foundation Health Plan of Kansas City, Inc.—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	14
	Extended care	All necessary services, up to 100 days per calendar year. **You pay** nothing	14
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 45 days of inpatient care reduced by one day for every two sessions of day or nightcare. **You pay nothing** for the first 30 days; 50% of charges for days 31-45; all charges thereafter	18
	Substance abuse	Up to 30 days of rehabilitative care per year. **You pay** nothing	19
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 Xrays; complete maternity care. **You pay** a $5 copay per office visit; nothing per house call by a doctor	11-12
	Home health care	All necessary visits by nurses and health aides. **You pay** nothing per visit	12
	Mental conditions	Up to 40 outpatient visits for individual therapy . **You pay** nothing for the first visit; $10 copay per visit for visits 2-20, and a $25 copay per visit for visits 21-40 and all charges thereafter.	18
	Substance abuse	All necessary outpatient visits. **You pay** nothing for the first visit and $20 for each subsequent visit	19
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** $50 for services provided at Plan facilities. **You pay** $50 for services provided at non-Plan facilities, inside the service area and $50 for services provided outside the service area. **You pay** $5 per urgent care center visit	16-17
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $3 copay per prescription unit or refill	20-21
Dental care		Accidental injury benefit. You pay 50% of the first $1,000 in charges per injury and all charges thereafter. Preventive dental care, comprehensive range of restorative, prosthetic, and other dental services. **You pay** copays for these services	22
Vision care		Refractions, including prescriptions for eyeglasses. **You pay** $5 per office visit	23
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,000 per Self Only or $3,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include prescription drugs or dental services. Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayment required for a few benefits	8

1999 Rate Information for

Kaiser Foundation Health Plan of Kansas City, Inc.

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

Postal rates apply to 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	HA1	$52.58	$17.52	$113.91	$37.97	$62.21	$7.89
Self and Family	HA2	$135.63	$45.21	$293.87	$97.95	$160.50	$20.34