KAISER PERMANENTE

Kaiser Foundation Health Plan of North Carolina

1999

A Health Maintenance Organization

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

Serving: Raleigh-Durham-Chapel Hill and Charlotte**,** North Carolina
Rock Hill area, South Carolina

Enrollment in this plan is limited; see page 8 for requirements

Enrollment Code:
QT1 Self Only
QT2 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:

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FEHB
Federal Employees Health Benefits Program

RI 73-240

Kaiser Foundation Health Plan of North Carolina

Kaiser Foundation Health Plan of North Carolina, 909 Aviation Parkway, Suite 600, Morrisville, North Carolina 27560-9153, has entered into a contract (CS 2064) 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 22.**

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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 1-800/755-1925 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 14. 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.

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

Coverage after enrollment ends

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

Former spouse coverage

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

Temporary continuation of coverage (TCC)

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

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

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

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

Notification and election requirements

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

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

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

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

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

case of a child and 60 days after the change in status in the case of a former spouse.

General Information *continued*

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 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 1/800-755-1925 or you may write the Carrier at 6350 Quadrangle Drive, Chapel Hill, North Carolina 27514. You may also contact the Carrier by fax at 919/403-4726 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 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 through our Medical Center Physician's Option, on a prepaid group practice basis, at nine Plan medical offices and through our Community Physician's Option at designated Physician offices conveniently located throughout the Raleigh, Durham, Chapel Hill and Charlotte **and Rock Hill** areas. Health Plan contracts with The Carolina Permanente Medical Group, P.A., an independent multi-specialty group of physicians, to provide or arrange all necessary physician care for Plan members. Medical care is provided through doctors, nurse practitioners and other skilled medical personnel working as medical teams. Specialists are available as part of the medical teams for consultation and treatment. Plan doctors also arrange for 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 available at Plan medical offices or by referral to specialists. Hospital care is

provided through the Plan at several local community hospitals.

Role of a primary care doctor

Choosing your doctor

Referrals for specialty care

Authorizations

For new members

Hospital care

Out-of-pocket maximum

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

Deductible carryover

The Plan's provider directory lists primary care doctors (generally family 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 Representative at 919/319-3070 in the Raleigh area or toll-free from anywhere in North Carolina at 1-800/755-1925; 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.

Submit claims promptly

If you enroll, you will be asked to select a primary care doctor for you and each member of your family and inform the Plan of your selection. You may see other Plan doctors if your primary care doctor is not available. Members may change their doctor selection by contacting Member Services.

Experimental/ Investigational determinations

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.

Other considerations

Except in a medical emergency, you must contact your 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 an authorization for the referral in advance.

This Plan's service area

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.

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.

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 the specialist.

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

Important notice

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 reach $3,300 per Self Only enrollment or $8,500 per Self and Family enrollment for total copayment charges required for services provided or arranged by the Plan. This copayment maximum does not include costs of prescription drugs, **the $25 charge for follow-up or continuing care, outpatient mental health beyond the 20th visit, chiropractic or dental services.**

Circumstances beyond Plan control

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.

Other sources of 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.

Medicare

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.

Group health insurance and automobile insurance

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.

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

CHAMPUS

The service area for this Plan, where Plan providers and facilities are located, is described **below.** You must live or work in the service area to enroll in this Plan. Benefits for care outside the service area are limited to emergency services, as described on page 14.

The service area for this Plan includes the following areas:

Raleigh-Durham-Chapel Hill Area, North Carolina
Alamance, Caswell, Chatham, Durham, Franklin, Granville, Harnett, Johnston, Nash, Orange, Person, Vance, Wake;

Medicaid

Charlotte Area, North Carolina

Workers' compensation

Cabarrus, Catawba, Gaston, Iredell, Lincoln, Mecklenberg, Rowan, Stanly, Union;

Rock Hill Area, South Carolina

Chester, Lancaster, York.

Benefits for care outside the service area are limited to emergency services, as described on page 14.

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 and care received at Kaiser Permanente facilities in other Kaiser Permanente Regions. Contact the Plan for further details on services available in other Kaiser Permanente Regions. The service area is the area within which the Plan's providers are most accessible.

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.

DVA facilities, DoD facilities, and Indian Health Service

Other Government agencies

Liability insurance and third party actions

What is covered?

General Limitations

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.**

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.

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.

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, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

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.

Limited benefits

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.

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

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).

General Limitations *continued*

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.

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

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 not covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits and laboratory tests and X-rays; you pay a $10 per office visit copay, but no additional copay for laboratory tests and X-rays. Office visits for prenatal care and well-baby care are provided at no charge. Within the service area, house calls will not be provided except by doctors, nurses and other professionals as part of the home health benefit listed below and if in the judgment of the Plan doctor such care is necessary and appropriate; you pay nothing for home health visits.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 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-physician providers and consultations with specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for covered females, including 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

What is covered?

Hospital care

be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn during the covered portion of the mother's confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of a newborn who requires definitive treatment will be covered only if the 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)

Extended care

- Visits to receive injections
- **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 lymphoma, 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.

Hospice care

- 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

Ambulance service

- **Dialysis** (Office visit charges will be waived if you enroll in Medicare Part B and assign your Medicare benefits to the Plan)

Limited benefits

- Chemotherapy, radiation therapy, and respiratory therapy
- Surgical treatment of morbid obesity

Inpatient dental procedures

- For homebound members residing in the service area, home health services of doctors, nurses and other professionals, when prescribed and directed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- Autologous blood donation expenses (including collection, processing, and storage costs) in connection with covered surgery recommended by a Plan doctor, RhoGham and gamma globulin

Acute inpatient detoxification

- 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
- Blood and blood products and the administration of blood
- Medical management of mental health conditions, including drug therapy evaluation and maintenance

What is not covered

If a member does not pay the applicable office visit charge at the time the service is 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.

Benefits Available Away From Home

Services From Other Kaiser Permanente Plans

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

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from 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. Reconstructive breast surgery resulting from a mastectomy, including reconstruction performed on a nondiseased breast to establish symmetry, when all or part of a breast is surgically removed for medically necessary reasons. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction. Reconstructive surgery is not covered after removal of breast implants originally inserted for cosmetic reasons.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two consecutive months per condition if significant improve-

Benefits available while you travel

ment can be expected within two months. **You pay $10** per outpatient session and nothing per 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.

Diagnosis and treatment of infertility is covered. **You pay 50%** of charges, up to your maximum member out-of-pocket expenses (as described on page 8) per calendar year and nothing thereafter. Injectable drugs and medications for the treatment of involuntary infertility are covered; you pay 50% of charges. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI), intrauterine insemination (IUI). **You pay 50%** of charges, up to your maximum member out-of-pocket expense (as described on page 8) per calendar year and nothing thereafter. The 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 transfers, are not covered. Infertility services are not available when either member of the family has been voluntarily sterilized. Drugs related to non-covered infertility treatments are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or myocardial infarction, is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within that two months. **You pay $10** per outpatient session, and nothing per inpatient session.

Durable medical equipment (DME), when intended to be used repeatedly and in the home is covered. Coverage is limited to the standard item of DME in accord with the Plan's formulary guidelines, that adequately meets the medical needs of the member. **You pay 20% of charges**. The following items are not covered: comfort and convenience equipment; exercise and hygiene equipment; disposable supplies; electronic monitors of the function of the heart or lungs (except apnea monitors for newborns), and devices to perform medical tests on blood or other bodily substances or excretions (except blood glucose monitors for diabetics); dental appliances; experimental or research equipment; devices not medical in nature such as sauna baths and elevators; and modifications to the home or auto.

External Prosthetic devices and braces are provided under Plan criteria as of January 1 of the prior year when prescribed by a Plan physician and obtained from sources designated by the Plan, including replacements, repair and adjustments other than those necessitated by misuse or loss. **You pay nothing**. Scoliosis braces are not covered.

What is a medical emergency?

Chiropractic Services (which are defined as manual manipulation of the spine to correct subluxation from sources designated by the Plan) are provided without referral. You pay $10 per visit for the first 30 visits in a calendar year; you pay all charges thereafter for any subsequent visits
in the same calendar year. Services exclude vax-d, vitamins and supplements, structural supports and massage therapies.

Emergencies within the service area

Rehabilitation is provided on an inpatient or outpatient basis as part of a specialized multidisciplinary therapy program in a specialized facility for up to two months per condition, when in the judgment of a Plan doctor, significant improvement can be expected within two months. **You pay $10** for outpatient care and nothing for inpatient care.

- 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
- **S**urgery primarily for cosmetic purposes
- Externally and internally implanted hearing aids
- All chiropractic services, except for manual manipulation of the spine to correct subluxation demonstrated by X-ray diagnosis of a Plan provider
- Orthopedic devices, foot orthotics; except braces
- Long term rehabilitative therapy
- Homemaker services
- Transplants not listed as covered
- Cognitive therapy
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism.

- Devices, equipment, supplies and prosthetics related to the treatment of sexual dysfunction.

Plan pays...

You pay...

Emergencies outside the service area

Plan pays...

You pay...

What is covered

What is not covered

Filing claims for non-Plan providers

Hospital/Extended Care Benefits

Mental conditions

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:

- 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

Outpatient 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:

Inpatient care

- 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

What is not covered

Supportive and palliative care for a terminally ill member is covered in the home. **You pay nothing.** Services include short-term inpatient, limited to respite care and care for pain control and acute and chronic symptom management, 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.

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

Substance abuse

What is covered

Outpatient care

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 would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Inpatient care

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 16 for nonmedical substance abuse benefits.

What is not covered

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

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.

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 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 hospital to receive care.

At the time you register for services, you will be asked to pay the charge required by your enrollment in 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, please call the Member Services Department at 1-800/755-1925.

Hospital/Extended Care Benefits *continued*

What is covered

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 Foundation Health Plan of North Carolina, Claims Department, P.O. Box 500489, Atlanta, Georgia 31150-1489. 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 follow-up or continuing care visits**. This amount will be deducted from the payment the Plan makes to you.

Emergency Benefits

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

Limited benefit

If you are in an emergency situation, please call your Plan facility or a Plan doctor. Describe the problem and you will be given instructions as to what should be done. In extreme emergencies, if you are unable to contact the Plan or your 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 when **it is reasonably possible to do so.** It is your responsibility to ensure that the Plan has been timely notified.

What is not covered

If you need to be hospitalized in a non-Plan facility, the Plan **must** be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in 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.

Dental care

Accidental injury benefit

Vision care

What is covered

Emergency Benefits *continued*

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

$50 per hospital emergency room visit **or $10** per urgent care center visit for emergency services that are covered benefits of this Plan, and any additional copays which would have been required if care had been rendered by the Plan. If the emergency results in admission to a hospital, the $**50** emergency care copay is waived.

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 Member Services Department at the following phone number: 1-800/755-1925. 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.

What is not covered

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

$50 per hospital emergency room visit or $10 per urgent care center visit for emergency services that are covered benefits of this Plan, and any additional copays which would have been required if care had been rendered by the Plan. If the emergency results in admission to a hospital, the $**50** emergency care copay is waived.

- Emergency care at a doctor's office or at an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. Submit claims to Kaiser Foundation Health Plan of North Carolina, Claims Department, P.O. Box 500489, Atlanta, Georgia, 31150-1489. 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 20.

Mental Conditions/Substance Abuse Benefits

Expanded dental benefits

Plan Select 35:

Monthly premium*

How to enroll

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 (each visit counts as one outpatient therapy visit). **You pay $10 per visit.**
- 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)

Up to **40** outpatient therapy visits to Plan doctors, consultants or other psychiatric personnel each calendar year. **You pay $10** per covered visit and all charges thereafter.

Up to 30 days of hospitalization each calendar year; you pay nothing for the first 30 days and all charges thereafter. Up to 60 days of day or night care per calendar year reduced by two days for each day of inpatient hospitalization and vice versa; you pay nothing for 60 days and all charges thereafter.

- 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

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

Up to 20 outpatient individual therapy visits or up to 40 group therapy visits to Plan doctors, consultants, or other substance abuse specialists each calendar year (each two group visits count as one individual visit). **You pay $10 per visit, $5 per group therapy visit** and all charges thereafter.

Up to 30 days of inpatient care or up to 60 sessions of care in an intensive outpatient treatment program (including day or night care) for specialized treatment per calendar year. Each inpatient day used reduces the number of intensive outpatient treatment sessions by two and vice versa. **You pay all daily charges over $100** for inpatient residential care and all daily charges over $50 for care in an intensive outpatient treatment program.

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.

- 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

BENEFITS ON THIS PAGE ARE NOT PART OF THE FEHB CONTRACT

Prescription Drug Benefits

Questions

Prescription drugs prescribed by Plan doctors or any dentists and obtained at a Plan pharmacy will be dispensed for up to a 90 day supply. **You pay $5 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. If you have selected the Community Physician's Option, your prescription may also be filled at a designated community pharmacy listed in your Physician Directory. You may have a prescription filled at a non-designated community pharmacy when it is written and filled after designated pharmacies are closed or as part of an out-of-area emergency. **You pay the full cost** of the prescription and then file a claim for reimbursement. If your claim is approved, you will be reimbursed the full cost of the prescription less $5.

Disputed claim review

Plan reconsideration

The Plan uses a formulary to determine which prescribed drugs will be provided to members. If the doctor or dentist specifically prescribes a nonformulary drug, and does not prescribe a substitution, the nonformulary drug will be covered. If you request the nonformulary drug when your doctor or dentist has prescribed a substitution, the 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.

OPM review

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

- Drugs for which a prescription is required by law
- Oral contraceptive drugs, contraceptive devices, diaphragms, cervical caps and intrauterine devices
- Implanted time-release drugs and injectable contraceptives. For Norplant, **you pay a one-time $200** per prescription charge. For Depo Provera, **you pay $15**. For all other internally-implanted time-release drugs and injectable contraceptives, **you pay a one-time payment equal to $5** per prescription times the expected number of months the drug will be effective, not to exceed $200. There will be no refund of any portion of these payments if the drug is removed before the end of its expected life.
- Insulin
- Diabetic supplies limited to glucose test strips, urine ketone, glucose or protein test strips
- Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU)
- Smoking cessation drugs. Coverage is limited to one course of treatment per calendar year under the following conditions: 1) the drug is prescribed by a Plan doctor; and 2) the member enrolls in and successfully completes a Plan approved behavioral intervention program.
- Drugs for covered infertility treatments. **You pay 50%** of charges
- Disposable needles and syringes needed to inject covered prescribed drugs; you pay nothing
- Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits

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

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.

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-designated 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 infertility services
- Drugs for non-covered services

Other Benefits

Restorative services, supplies and appliances 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 and all charges thereafter.

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, this Plan provides the following vision care benefits to members when prescribed by doctors or optometrists associated with the Plan and provided at Plan facilities or designated sources:

- Refractions for corrective lenses (once every 24 months). **You pay nothing**.
- Frames for corrective lenses are provided once every 24 months. **You pay nothing** for frames that cost less than $20. You receive a $20 credit toward frames that cost more than $20.
- Regular corrective lenses are provided once every 24 months. (They may be provided more often if there is a significant change in your vision). **You pay nothing**.
- Medically required contact lenses are provided instead of regular corrective lenses. (Specific medical criteria must be met.) **You pay nothing**.
- Corrective contact lenses prescribed primarily for vision correction for conditions which do not meet specific criteria may be provided once every 24 months instead of regular corrective eyeglass lenses. **You pay nothing** for lenses that cost less than $40; for other types of lenses, you receive a credit of $40.
- After eye surgery, regular corrective lenses and contact lenses are provided at the same time when, if worn at the same time, they provide a significant improvement in vision that cannot be obtained by regular corrective lenses or contact lenses alone. **You pay nothing**.
- Industrial and athletic safety frames and lenses
- Plain (non-corrective) sunglasses
- No-line bifocals
- Plain (non-corrective) contact lenses for cosmetic purposes
- Replacement of lost or broken lenses, frames or contacts
- Lens adornment
- Fittings for contact lenses which are not medically required
- Eye exercises

How Kaiser Foundation Health Plan of North Carolina 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 their 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 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 14).

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.

Benefits changes

The copayment for emergency room services received within the service area will increase from $25 to $50 per visit. The $50 copayment will be waived if the emergency results in an admission to a hospital. See page 15.

The copayment for emergency room services received outside the service area will increase from $25 to $50 per visit. The $50 copayment will be waived if the emergency results in an admission to a hospital. See page 15.

The coinsurance for durable medical equipment has increased from zero to 20% of charges. See page 12.

A $10 administrative charge will be added to any office visit charge that is not paid at the time the member receives the service. See page 11.

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.

Chiropractic services (defined as manual manipulation of the spine to correct subluxation) from sources designated by the Plan are provided without a referral. You pay $10 per visit for each of the first 30 visits in a calendar year and all changes thereafter. See page 12.

Dialysis services require payment of the office visit charge, except that members covered by Medicare Part B of Medicare who assign their benefits to the Plan will have the office visit charge waived. See page 11.

In addition to coverage for reconstructive surgery for defect or injury, reconstructive surgery after mastectomy will also be covered, including reconstruction on the nondiseased breast to establish symmetry. See page 11.

Devices, equipment supplies and prosthetics related to sexual dysfunction are not covered. See page 12.

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

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 who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, or out-of-pocket maximum. These benefits are not subject to the FEHB disputed claims procedures.

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

Inpatient care

Hospital

Kaiser Permanente is pleased to offer Federal employees, retirees, and dependents a dental program to supplement your medical plan. This coverage is through American Dental Plan.

CompDent Corporation offers dental health maintenance organization (HMO) benefits administered by American Dental Plan of North Carolina, Inc. (ADP). With this plan, you must pre-identify a primary care dentist from the list of ADP dentists that is most convenient to you and your family. With ADP, there are no claim forms to worry about. ADP also provides a full range of services that includes: preventive, restorative, endodontics, periodontics, prosthetics, and orthodontics. Under this program, the subscriber pays a copayment for all services which means a discount of approximately fifty percent (50%) off all covered services.

Extended care

Mental conditions

Substance abuse

Individual	$9.40
Two-Persons	$16.00
Family	$22.10

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

Outpatient care

Please use the enclosed postage paid card to request an application. Call toll-free 1-800/542-1146 and identify yourself as a Federal employee interested in the Kaiser Permanente/ADP Select 35 dental plan.

Payment for the Select 35 plan must be made by automatic monthly withdrawal from your checking, savings, or credit union or by an annual payment by check or money order.

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

Home health care

Mental conditions

Substance abuse

Emergency care

Prescription drugs

Dental care

Vision care

Out-of-pocket maximum

1999 Rate Information for Kaiser Foundation Health Plan of North Carolina

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	**QT1**	**54.06**	**18.02**	**117.13**	**39.04**	**63.97**	**8.11**
Self and Family	**QT2**	**160.39**	**55.85**	**347.51**	**121.01**	**183.29**	**32.95**