Kaiser Foundation Health Plan of Georgia, Inc.

1999

A Health Maintenance Organization

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

Serving: Atlanta, Georgia metropolitan area
Enrollment in this plan is limited; see page 8 for requirements.

Enrollment Code:
F81 Self Only
F82 Self and Family

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

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Kaiser Foundation Health Plan of Georgia, Inc.

The Kaiser Foundation Health Plan of Georgia, Inc.; Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, Georgia 30305-1736, has entered into a contract (CS 2163) 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** of this brochure.

Table of Contents

Page

Inspector General Advisory on Fraud **3**

General Information **3-6**

Confidentiality; If you are a new member; If you are hospitalized when you change plans; Your responsibility; Things to keep in mind; Coverage after enrollment ends (Former spouse coverage; Temporary continuation of coverage; Conversion to individual coverage; and Certificate of Creditable Coverage)

Facts about this Plan **6-8**

Information you have a right to know; Who provides care to Plan members? Role of a primary care doctor; Choosing your doctor; Referrals for specialty care; Authorizations; For new members; Hospital care; Out-of-pocket maximum; Deductible carryover; Submit claims promptly; Experimental/Investigational determinations; Other considerations; The Plan's service areas

General Limitations **9-10**

Important notice; Circumstances beyond Plan control; Other sources of benefits

General Exclusions **10**

Benefits **10-17**

Medical and Surgical Benefits; Hospital/Extended Care Benefits; Travel Benefits/Benefits Available Away from Home; Emergency Benefits; Mental Conditions/Substance Abuse Benefits; Prescription Drug Benefits

Other Benefits **18**

Dental care; Vision care

Non-FEHB Benefits **19**

How to Obtain Benefits **20-21**

How Kaiser Foundation Health Plan of Georgia, Inc. Changes January 1999 ..... **22**

Summary of Benefits **23**

Rate Information **24**

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).

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 (404) 261-2590 or you may write the carrier at Kaiser Permanente, Nine Piedmont Center, 3495 Piedmont Road, N.E., Atlanta, Georgia 30305-1736. You may also contact the Carrier by fax at (404) 364-4939 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 on a prepaid group practice basis, at nine Plan medical centers conveniently located throughout the Atlanta metropolitan area and through referral specialists, hospitals and other providers in the community. Except in an emergency, all care should be received at these medical offices and from these providers. Health Plan contracts with The Southeast Permanente Medical Group, Inc., an independent multispecialty group of physicians ("Plan doctors"), to provide or arrange all necessary physician care for Plan members. Plan doctors are members of American Specialty Boards or are Board eligible. Medical care is provided through doctors and other skilled medical personnel working as medical teams at Kaiser Permanente medical offices. Plan doctors also arrange any necessary specialty care. Other necessary medical services, such as physical therapy, laboratory and X-ray services, are also available at Kaiser Permanente medical offices or on referral to local community providers. Hospital care is provided through the Plan at several local community hospitals. Health Plan contracts with American Dental Plan (ADP) to provide or arrange covered dental care for Plan members.

Facts about this Plan *continued*

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 $2,000 per Self Only enrollment or $5,000 per Self and Family enrollment. This copayment maximum does not include costs of prescription drugs, **the $25 charge for follow-up or continuing care, chiropractic services** or dental services.

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

Deductible carryover

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

Submit claims promptly

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

Experimental/ Investigational determinations

A service is experimental or investigational if it is: (1) not approved by the FDA; (2) the subject of a new drug or new device application on file with FDA; or (3) part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or (4) provided pursuant to a written protocol that evaluates the service's safety, toxicity, or efficacy; or (5) subject to the approval or review of an Institutional Review Board; or (6) provided pursuant to informed consent documents that describe the service as experimental or investigational. The Plan and its Medical Group carefully evaluate if a particular therapy is either proven to be safe and effective or offers a degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical literature.

Other considerations

Plan providers will follow 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

This Plan's service area

The service area for this Plan, where Plan providers and facilities are located, is described **below.** You must live in the service area to enroll in this Plan. Benefits for care outside the service area are restricted to emergency care and care received at Kaiser Permanente facilities in other Kaiser Permanente Regions. See the Plan for further details.

Service area: Services from Plan providers are available only in the following areas:

The Georgia counties of Bartow, Barrow, Butts, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale, Spalding and Walton.

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 *continued*

DVA facilities, DoD facilities, and Indian Health Service

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

Other Government agencies

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

Liability insurance and third party actions

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

General Exclusions

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

The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies and services received under the Travel Benefit (see Emergency Benefits and Benefits Available Away from Home);
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs, or devices that are experimental or investigational;
- Procedures, services, drugs, and supplies related to sex transformations; and
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

Medical and Surgical Benefits

What is covered?

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office and outpatient surgery visits. **You pay $10 per office visit charge**, but no additional copay for laboratory tests and X-rays. Within the service area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate: you pay a $10 copay for a doctor's house call and nothing for home visits by doctors, nurses and health aides.

The following services are included:

- Preventive care, including well-baby care for children over 2 years of age and periodic check-ups
- Mammograms are covered as follows: for women age 35 through 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters; **you pay nothing**
- Visits to primary care doctors, non-physician providers and consultations with specialists
- Diagnostic procedures, such as laboratory tests and X-rays. **You pay nothing**

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. Except as shown on page 18 under dental benefits, all other procedures involving the teeth or areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes and correction of malocclusion.

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.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months. **You pay nothing for inpatient care and $10 per outpatient 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. Vocational rehabilitation is not covered.

Diagnosis and treatment of infertility is covered; **you pay 50% of charges**. The following types of artificial insemination are covered: intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI); **you pay 50% of charges**; cost of donor sperm and donor eggs and services related to their procurement and storage is not covered. Fertility drugs are covered under the Prescription Drug Benefit. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization, gamete and zygote intra fallopian transfer, are not covered. Infertility services are not available when either member of the family has been voluntarily surgically sterilized.

Cardiac rehabilitation following a heart transplant, bypass surgery or myocardial infarction, is provided concurrently with other short-term therapy for up to two consecutive months per acute condition if significant improvement can be expected within two months. **You pay $10 per outpatient session, and nothing per inpatient session**.

Chiropractic services from sources designated by the Plan are provided. **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.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, or governmental licensing.
- Reversal of voluntary, surgically-induced sterility
- **S**urgery primarily for cosmetic purposes
- Homemaker services
- External and internally implanted hearing aids
- Transplants not listed as covered
- Long-term rehabilitative and cognitive therapy
- Orthotic foot supports and inserts
- Refractions for contact lenses
- Corrective eyeglasses and frames or contact lenses (including the fitting of the lenses)
- 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.**

1-404/261-2590.

Hospital/Extended Care Benefits *continued*

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, drug 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 Georgia, Inc., Claims Administration, P.O. Box 500519, Atlanta, GA 31150-0519. If the services are covered under this Travel Benefit, you will be reimbursed the reasonable charges for the care, up to a maximum of $1,200 per calendar year. **You pay $25** for each follow-up or continuing care visit. This amount will be deducted from the payment the Plan makes to you.

Emergency Benefits

What is a medical emergency?

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

Some situations may require prompt medical attention but are not or may not be an emergency as described above. Medical services to treat these situations are available to you at Kaiser Permanente After Hours Offices, or at Health Plan designated Urgent Care Centers.

Emergencies within the service area

If you are in an emergency situation, please call your Plan facility. After office hours, call 404/**365-0966**. If calling long distance, call 1-800/**611-1811.**

In extreme emergencies, if you are unable to contact your doctor or facility, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours**,** unless it was not reasonably possible to do so**.** It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours 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.

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

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
- Psychiatric treatment (including individual and group therapy)
- Medical management visits, including drug evaluation and maintenance
- Hospitalization (including inpatient professional services)

Outpatient care

Outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; **you pay nothing** for visits 1-5, **$15** per visit for visits 6-40, and **50% of charges thereafter for each visit in the same calendar year.**

Inpatient care

Inpatient days; you pay nothing for the first 30 days of hospitalization each calendar year, and 50% of charges thereafter for each day in the same calendar year.

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

What is not covered

- Care for psychiatric conditions 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

Up to 30 outpatient visits to Plan doctors, consultants or other substance abuse specialists each calendar year for the treatment of alcohol or drug abuse when prescribed by a Plan doctor and provided at a designated facility, and necessary aftercare visits when provided as part of a covered program and prescribed by a Plan doctor. A visit may consist of an individual therapy visit or up to a day visit to a specialized facility; the Plan doctor will determine the appropriate type of visit. **You pay nothing** for each covered visit — all charges thereafter.

Inpatient care

Inpatient treatment for the psychiatric aspects of substance abuse is limited to the inpatient mental conditions benefit listed above.

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

What is not covered

- Treatment that is not authorized by a Plan doctor
- Inpatient treatment in a specialized treatment facility
- 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

Other Benefits

Dental care

What is covered

The following preventive dental services are covered when provided by participating Plan dentists. **You pay $14** per visit:

- Oral examinations twice a year
- Dental prophylaxis (cleaning) twice a year
- Topical application of fluoride twice a year when prescribed by a Plan dentist
- Bitewing X-rays twice a year
- Full mouth series X-ray once every three years

You receive a 10% discount from the Plan dentist's usual and customary fee schedule for all other dental care

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered when provided by any dentist. **You pay 50% of the first $1,000** in charges per accidental injury and all charges thereafter.

Non-surgical treatment of temporomandibular joint dysfunction

Non-surgical treatment of temporomandibular joint dysfunction (TMJ), including splints and appliances, is covered. Services must be provided by participating Plan dentists; **you pay 50% of the first $1,000** in charges per calendar year and all charges thereafter.

What is not covered

- Other dental services not specifically shown as covered

Vision care

What is covered

Eye refractions for eyeglasses (to provide written lens prescription) may be obtained from Plan providers. **You pay** $15 per visit

What is not covered

- Corrective eyeglasses and frames or contact lenses (including the examination and fitting of contact lenses)
- Refractions for contact lenses
- Eye exercise

Special Benefits for Medicare Eligible Enrollees

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

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

Like your FEHB 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 Federal Employees Kaiser Permanente Senior Advantage packet. For a copy of these rules, please contact our Medicare Department at 1-888/468-0100.

Following your enrollment in Kaiser Permanente Senior Advantage, you will be entitled to receive an enhanced benefits package that combines your FEHB 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 complete and sign an application to enroll in Senior Advantage. You must also continue to pay the employee share of the FEHB premium. You can return to FEHB coverage alone, at any time. Your disenrollment will become effective the first day of the month after we receive your completed Senior Advantage disenrollment form.

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 404/261-2590 or 1-800/255-0568 TDD or you may write to the Plan at Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, Georgia 30305-1736. You may also contact the Plan by fax at 404/364-4939 or at its website at http://www.kaiserpermanente.org.

Disputed claim review

Plan reconsideration

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

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

OPM review

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

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

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

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

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

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.
- Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

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

How Kaiser Foundation Health Plan of Georgia, 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 7 for details).

A medical emergency is defined as the sudden and unexpected onset of a condition or injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care (See page 14).

The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Examples include attention deficit disorder and Gilles de la Tourette's syndrome. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 40 outpatient Mental Conditions visit limit.

Changes to this Plan

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

The copayment for office and outpatient surgery visit, outpatient rehabilitation and short term rehabilitation session, and house calls by a doctor will increase from $5 to $10 per visit. See page 10.

The copayment for prescription drugs will increase from $3 to $5 per prescription or refill to $9 to $11 per prescription or refill. See page 17.

Each visit to a hospital emergency room will require Members to pay $50. The $50 copayment will be waived if the emergency results in an admission to a hospital. See page 15.

The coinsurance for the diagnosis and treatment of infertility has increased from 30% of charges to 50%. See page 12.

The coinsurance for drugs associated with the treatment of involuntary infertility has increased from 30% to 50%. See page 17.

The coinsurance for durable medical equipment has increased from zero to 20% of charges. See page 11.

Chiropractic services are now offered without a referral from sources designated by the Plan. You pay $10 per visit for the first 30 visits in a calendar year; all charges thereafter. See page 12.

The number of covered outpatient mental health visits and inpatient mental health days are now unlimited in a calendar year. For inpatient care, you now pay nothing for the first 30 days and 50% of all charges thereafter. For outpatient care you pay nothing for visits 1-5, $15 for visits 6-40 and 50% of all charges thereafter. See page 16.

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.

After Hours or Urgent Care services are provided at Kaiser Permanente After Hours Offices or at Health Plan Designated Urgent Care Centers. See page 14.

Drugs to treat sexual dysfunction are covered under the Prescription Drug Benefit. See page 17.

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

Federal annuitants with Part A and B of Medicare may enroll in this Plan's Senior Advantage Program, also known as Medicare Risk or Medicare+Choice. See page 18.

Dialysis services will be provided at the office visit charge of $10. However, if a member is covered by Part B of Medicare and assigns to the Plan the right to collect payment from Medicare for these services, the office visit charge will be waived. See page 11.

1999 Rate Information for Kaiser Foundation Health Plan of Georgia, 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	**F81**	**63.15**	**21.05**	**136.82**	**45.61**	**74.73**	**9.47**
Self and Family	**F82**	**160.31**	**53.44**	**347.35**	**115.78**	**183.29**	**30.46**