Kaiser Foundation Health Plan, Inc.
California Division 2000

KAISER PERMANENTE®

A Health Maintenance Organization

Serving: Northern/Southern California service area

Enrollment in this Plan is limited; see page 6 for requirements.

Enrollment code:

591 Self only

592 Self and family

Enrollment code:

621 Self only

622 Self and family

This Plan has commendable accreditation from the NCQA. See the *2000 Guide* for more information on NCQA.

Visit the OPM website at http://www.opm.gov/insure

and

our national website at **http://www.kaiserpermanente.org**

Authorized for distribution by the

UNITED STATES OFFICE OF
PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE

FEHB
Federal Employees
Health Benefits Program

RI 73-003

Table of contents

Introduction

Kaiser Foundation Health Plan, Inc., California Division

1950 Franklin, Oakland, CA 94612 (Northern Division)

393 East Walnut Street, Pasadena, CA 91188 (Southern Division)

This brochure describes the benefits you can receive from Kaiser Foundation Health Plan, Inc., California Division under its contract (CS 1044) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 5. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health Plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Kaiser Foundation Health Plan, Inc., California Division as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not rewritten the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. **Health Maintenance Organizations (HMO).** This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. **How we change for 2000.** If you are a current member and want to see how we have changed, read this section.

3. **How to get benefits.** Make sure you read this section; it tells you how to get services and how we operate.

4. **What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. **General exclusions—Things we don't cover.** Look here to see benefits that we will not provide.

7. **Limitations—Rules that affect your benefits.** This section describes limits that can affect your benefits.

8. **FEHB facts.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventive care such as routine office visits, physical exams, well-baby care, and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services, or follow-up or continuing care under this Plan's travel benefit, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Programwide changes

To keep your premium as low as possible, OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB Program. (See Section 3, How to get benefits, for more information.)

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you with your records, call us and we will assist you.

Changes to this Plan

- Your share of the non-Postal premium for code 59 will increase by 8% for Self Only or 7.9% for Self and Family.
- Your share of the high option premium for code 62 will increase by 5.0% for Self Only or 5.0% for Self and Family.
- The copay for primary care office visits will increase from $5 to $10. (See page 12).
- Blood glucose monitors for diabetics will be covered with a $5 copay per prescription. (See page 13).
- The copay for emergency services will increase from $25 to $35 per visit. (See page 17).
- Non-medical residential substance abuse care services that provide counseling and support services will be covered at a charge of $100 per admission. Previously this benefit was limited to Southern California service area members. (See page 20).
- Disposable needles and syringes needed for injecting covered prescribed drugs will be covered at a charge of $5 for up to a 90-day supply. (See page 21).

Section 3. How to get benefits

What is this Plan's service area?

To enroll in this Plan, you must live or work in our service area. This is where our providers practice. Our service area is:

These Northern California counties: Alameda; Contra Costa; Marin; Sacramento; San Francisco; San Joaquin; San Mateo; Solano; Stanislaus

These Northern California zip codes:

Amador County: 95640, 95669

El Dorado County: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762

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

Kings County: 93230–32

Madera County: 93601, 93604, 93614, 93637–39, 93643–45, 93653, 93669

Mariposa County: 93623

Napa County: 94508, 94515, 94558–59, 94562, 94567, 94573–74, 94576, 94581, 94599

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

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

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

Sutter County: 95622, 95659, 95668, 95674, 95676

Tulare County: 93618, 93666, 93673

Yolo County: 95605, 95607, 95612, 95616–18, 95645, 95694–95, 95697–98, 95776, 95798–99

Yuba County: 95692, 95903, 95961

These Southern California zip codes: 90000–099, 90100–199, 90200–299, 90300–399, 90400–499, 90500–599, 90600–699, 90700–799 (except 90704), 90800–899, 91000–099, 91100–199, 91200–299, 91300–399, 91400–499, 91500–599, 91600–699, 91700–799, 91800–899, 91901–03, 91808–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91990–91, 92007–09, 92014, 92018–27, 92029–30, 92033, 92037–40, 92046, 92049, 92051–58, 92064–65, 92067–69, 92071–72, 92074–75, 92079, 92082–85, 92090–93, 92096, 92100–199, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92252–56, 92258, 92260–64, 92268, 92270, 92274–78, 92282, 92284–86, 92292, 92305, 92307–08, 92313–18, 92320–22, 92324–26, 92329, 92333–37, 92339–41, 92345–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–94, 92397, 92399, 92400–499, 92500–532, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–82, 92595–96, 92599, 92600–699, 92700–799, 92800–899, 93000–009, 93010–12, 93015–16, 93022, 93030–35, 93040, 93041–44, 93060–61, 93062–66, 93093, 93099, 93203, 93205–06, 93215–16, 93220, 93222, 93224, 93225, 93226, 93238, 93240–41, 93243, 93250–52, 93261, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–13, 93380–90, 93501–02, 93504–05, 93510, 93518–19, 93531–32, 93534–36, 93539, 93543–44, 93550–53, 93560, 93561, 93563, 93581, 93584, 93586, 93590–91, 93599

Section 3. How to get benefits *continued*

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente service area, you can receive virtually all of the benefits of this Plan at any other Kaiser Permanente facility. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described on page 16; and for emergency care obtained from any non-Plan provider, as described on page 17. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents permanently reside outside of the area, you should consider enrolling in another plan. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employment or retirement office.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services. If you do not pay at the time you receive your service, you will be billed for the service. We also will bill you an additional $5. This charge will be added to each service for which you did not pay.

After you pay $1,500 in copayments or coinsurance for one family member, or $3,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments or coinsurance for your costs of prescription drugs, dental services, contraceptive devices, cosmetic services, chiropractic services, the $25 charges paid for follow-up or continuing care, and all mental conditions services except the first 20 outpatient visits do not count toward these limits, and you must continue to pay for these services as described in this brochure.

Be sure to keep accurate records of your copayments and coinsurance, since you are responsible for informing us when you reach the limits.

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us, or you receive follow-up or continuing care under the travel benefit. If you file a claim, please send us all of the documents we need to respond to your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

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

You must receive your health care services at Plan facilities, except if you have an emergency. If you are visiting another Kaiser Permanente service area, you may receive health care services at those Kaiser Permanente facilities. This Plan also offers a benefit that will allow you to receive follow-up or continuing care while you travel anywhere.

Section 3. How to get benefits *continued*

Your primary care physician (PCP)—either a family practitioner, pediatrician, gynecologist, or internist—will coordinate most aspects of your health care, including arranging for you to receive services from a specialist. This Plan will cover specialists' services only when your primary care physician refers you. You also may receive mental health or optometry services without a referral.

The Plan's facilities directory lists the Plan's facilities and services, with the locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling our Member Services Call Center at 800/464-4000. Use your directory to:

- Receive more information about facility locations and services,
- Receive information about how to get established with a Plan physician.

Notify the Plan of the primary care physician you choose. If you need help choosing a PCP, call the Plan. You may change your primary care physician at any time. You are free to see other Plan physicians if your primary care physician is not available, and to receive care at other Kaiser Permanente facilities.

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Your primary care physician or specialist will make the necessary arrangements and continue to coordinate your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our Member Service Call Center at 800/464-4000. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center, or
- The day your benefits from your former plan run out, or
- The 92nd day after you became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will determine if you need care from a specialist and will refer you to the appropriate provider. The referral will describe the services you will receive. You should return to your primary care physician after your consultation with the specialist. If your specialist recommends additional visits or services, your primary care physician will review the recommendation and authorize the visits or services, as appropriate. You should not go to a specialist unless your primary care physician and your Plan have authorized the referral.

If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a specified number of visits. You will not need to obtain additional referrals.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If your primary care physician decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

Section 3. How to get benefits *continued*

What do I do if my specialist leaves the Plan?

Call your primary care physician who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your physician for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN (provider) until the end of your postpartum care.

You may also be able to continue seeing your physician if this Plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current physician until the end of your postpartum care.

How do you authorize medical services?

Your physician will make all necessary arrangements before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before these arrangements can be made, we consider if the service is medically necessary to prevent, diagnose, or treat an illness or condition. We follow generally accepted medical practice in providing services to you.

How do you decide if a service is experimental or investigational?

When the service or supply, including a drug: (1) has not been approved by the FDA; or (2) is the subject of a new drug or new device application on file with the FDA; or (3) is 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) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or (5) is subject to the approval or review of an Institutional Review Board; or (6) requires an informed consent that describes the service as experimental or investigational; then this Plan considers that service, supply, or drug to be experimental, and not covered by the Plan. This Plan and its Medical Group carefully evaluate whether a particular therapy is 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.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing;

2. Refer to specific brochure wording explaining why you believe our decision is wrong; and

3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;

2. Pay the claim;

3. Arrange for a health care provider to give you the service; or

4. Ask for more information.

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life-threatening condition and you haven't responded to my request for service?

Call us at 800/464-4000 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.

2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

Section 4. What to do if we deny your claim or request for service *continued*

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;

2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;

3. Copies of all letters you sent us about the claim;

4. Copies of all letters we sent you about the claim; and

5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;

2. The estate of a person once enrolled in the Plan; and

3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to?

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

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of Title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits—Medical and surgical benefits

A comprehensive range of preventive, diagnostic, and treatment services is provided by Plan physicians and other Plan providers. This includes all necessary office and outpatient surgery visits; **you pay** a $10 per office visit copayment, but nothing for ultraviolet light therapy treatment visits, laboratory tests, and x-rays. Within the service area, the home health services benefit is provided as listed below and if in the judgment of the Plan physician such care is necessary and appropriate; you pay nothing for home health visits by nurses and health aides.

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

- Preventive care, including well-baby care and periodic check-ups. All scheduled preventive Pediatric Department office visits for children from birth until age two will be provided at no charge.
- Mammograms—for women age 35 through 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years at no charge. In addition to routine screening, mammograms are covered when prescribed by the physician to diagnose or treat your illness.
- Routine immunizations and boosters at no charge.
- Consultations by specialists.
- Diagnostic procedures, such as laboratory tests and x-rays.
- Complete obstetrical (maternity) care for all covered females including prenatal, delivery, and postnatal care by a Plan physician. Following confirmation of pregnancy, all medically necessary Obstetrical Department prenatal visits and the first postpartum visit will be provided at no charge. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn during the covered portion of the mother's confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of a newborn who requires definitive treatment will be covered only if the newborn is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services.
- Diagnosis and treatment of diseases of the eye.
- Allergy testing and treatment, including test and treatment materials (such as allergy serum) will be provided at no charge.
- Blood and blood products and the administration of blood (no charge).
- The insertion of internal prosthetic devices such as pacemakers and artificial joints.
- Cornea, heart, heart-lung, kidney, pancreas-kidney, simultaneous pancreas-kidney, liver and lung (single or double) transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic 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.
- 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.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

Section 5. Benefits—Medical and surgical benefits *continued*

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

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

Limited benefits

Oral and maxillofacial surgery is provided for non-dental 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 intraoral areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and their attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

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

Durable medical equipment (DME), when intended to be used repeatedly and in the home, is covered. Coverage is limited to the standard item of DME in accord with the Plan's formulary guidelines, that adequately meets the medical needs of the member. Covered items include ostomy and urological supplies and apnea monitors for newborns. **You pay** nothing. Blood glucose monitors for diabetics are covered. **You pay** $5. 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; devices to perform medical tests on blood or other bodily substances or excretions; dental appliances; experimental or research equipment; devices not medical in nature such as sauna baths and elevators; and modifications to the home or auto; chiropractic appliances, except as specifically provided in the chiropractic benefit.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

Section 5. Benefits—Medical and surgical benefits *continued*

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

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

Diagnosis and treatment of infertility is covered. **You pay** $10 per office visit. The following types of artificial insemination are covered: intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI); **you pay** $10 per office visit; cost of donor sperm and donor eggs and services related to their procurement and storage is not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization, gamete and zygote intrafallopian transfer, are not covered. Infertility services are not available when either member of the family has been voluntarily surgically sterilized. Drugs used for covered infertility treatments are provided under the Prescription Drug Benefit. Drugs related to non-covered infertility treatments are not covered.

What is not covered

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

Section 5. Benefits—Hospital/extended care benefits

What is covered

Hospital care

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

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

Extended care

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

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

Hospice care

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

Ambulance service

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

Limited benefits

Inpatient dental procedures

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

Acute inpatient detoxification

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

What is not covered

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

Section 5. Benefits—Benefits available away from home

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

Services from other Kaiser Permanente Plans

When you are visiting in the service area of another Kaiser Permanente Plan, you are entitled to receive virtually all the benefits described in this brochure at any Kaiser Permanente medical office or Medical Center and from any Kaiser Permanente provider. (If the Plan you are visiting has a charge that is different from the charges listed in this brochure, you will have to pay the charges imposed by the Plan you are visiting.) If the Kaiser Permanente Plan in the area you are visiting has a benefit that is different from the benefits of this Plan, you are not entitled to receive that benefit. Some services covered by this Plan, such as artificial reproductive services and the services of specialized rehabilitation facilities, will not be available in other Kaiser Permanente service areas. If a benefit is limited to a specific number of visits or days, you are entitled to receive only the number of visits or days covered by the Plan in which you are enrolled. If you are seeking routine, non-emergent or non-urgent services, you should call the Kaiser Permanente Member Services Department in that service area and request an appointment. You may obtain routine follow-up or continuing care from these Plans, even when you have obtained the original services in the service area of this Plan. If you require emergency services as the result of an unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care.

At the time you register for services, you will be asked to pay the copayment required under 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 from that Kaiser Permanente Plan, please call the Member Service Call Center at 800/464-4000.

Benefits available while you travel

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

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

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

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

Section 5. Benefits—Emergency benefits

What is a medical emergency

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

Emergencies within the service area

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

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

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

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

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

You pay...$35 per hospital emergency room visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the charge is waived.

Emergencies outside the service area

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente Plan. The facilities will be listed in the local telephone book under “Kaiser Permanente.” These numbers are open 24 hours a day, 7 days a week. You may also obtain information about the location of facilities by calling the Member Service Call Center at 800/464-4000.

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

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

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

You pay...$35 per hospital emergency room visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the charge is waived.

Section 5. Benefits—Emergency benefits *continued*

What is covered

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

What is not covered

- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area

Filing claims for non-Plan providers

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

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 10.

Section 5. Benefits—Mental conditions/Substance abuse benefits

What is covered

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

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

Outpatient care

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

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

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

Inpatient care

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

Day and night care

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

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan physicians 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 physician to be necessary and appropriate.
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Section 5. Benefits—Substance abuse

What is covered

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

Inpatient care

- Short-term recovery services, including counseling and support. **You pay** nothing. Up to 60 days per calendar year (maximum of 120 days in any five consecutive calendar years) in a non-medical residential care facility that provides counseling and support services will be provided when prescribed by a Plan physician; you pay $100 per admission.
- Methadone treatment for a pregnant member at licensed treatment centers throughout the pregnancy and for two months after delivery. **You pay** nothing.

Outpatient care

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

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

What is not covered

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

Section 5. Benefits—Prescription drug benefits

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

The Plan uses a formulary to determine which prescribed drugs will be provided to members. If the physician specifically prescribes a non-formulary drug because it is medically necessary, the non-formulary drug will be covered. If you request the non-formulary drug when your physician has prescribed a substitution, the non-formulary drug is not covered. However, you may purchase the non-formulary drug from a Plan pharmacy at prices charged to members for non-covered drugs.

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

  (1) the drug is prescribed by a Plan physician; and

  (2) the member enrolls in a Plan-approved behavioral intervention program
- Disposable needles and syringes needed for injecting covered prescribed drugs.

The Plan provides the following at no charge:

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

Section 5. Benefits—Prescription drug benefits *continued*

Limited benefits

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

What is not covered

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

Benefits—Other benefits

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, eye refractions (to provide a written lens prescription for eyeglasses, but not for contact lenses) may be obtained from Plan providers. **You pay** a $10 copayment per visit.

What is not covered

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

Section 5. Benefits—Other benefits *continued*

Special benefits for Medicare-eligible enrollees

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

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

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

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

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

Non-FEHB benefits available to Plan Members

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

Eyewear discount

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

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

Expanded dental benefits

Kaiser Permanente is pleased to offer Federal employees, retirees, and dependents a choice of dental coverages to supplement your medical plan.

OPTION I/DeltaCare

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

OPTION II/ KPIC's Dental Plan

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

Monthly premium*	OPTION I	OPTION II	
	DeltaCare		KPIC's Dental Plan
	Monthly Premium	Quarterly Premium	Monthly Premium
Self Only	$ 8.25	$24.75	$19.90
Self & One Party	$13.80	$41.39	$35.40
Self & Two or More	$20.92	$62.76	$53.20

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

How to enroll

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

Payments for the KPIC's Dental Plan or DeltaCare programs will be made by automatic withdrawal from your checking, savings, or credit union account.

• These rates are effective January 1, 2000, through December 31, 2000.

Benefits on this page are not part of the FEHB contract

Section 6. General exclusions—Things we don't cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless your Plan physician determines it is medically necessary to prevent, diagnose, or treat your illness or condition.

We do not cover the following:

- Services, drugs, or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- 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);
- Experimental or investigational procedures, treatments, drugs, or devices;
- 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;
- Procedures, services, drugs, and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations—Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

If you involuntarily lose coverage or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 800/638-6833. For information on the Medicare+Choice plan offered by this Plan (Kaiser Permanente Senior Advantage), see page 23.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

Section 7. Limitations—Rules that affect your benefits *continued*

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

Under certain extraordinary circumstances, we may have to delay your services or be unable to provide them. In that case, we will make all reasonable efforts to provide you with necessary care.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages, you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

If you have a malpractice claim

If you have a malpractice claim because of services you did or did not receive from a Plan provider, it must go to binding arbitration. Contact us about how to begin our binding arbitration process.

Section 8. FEHB facts

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers, and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs, and how we determine if procedures are experimental or investigational. OPM's website http://www.opm.gov/insure lists the specific types of information that we must make available to you.

If you want specific information about us, call 800/464-4000, or write to Kaiser Foundation Health Plan, Inc., P.O. Box 23059, San Diego, CA 92193-3059. You may also visit our website http://www.kaiserpermanente.org or e-mail us at Callcenter.webmail@cal.kaiperm.org.

Where do I get information about enrolling in the FEHB Program?

Your employing or retirement office can answer your questions and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- The next Open Season for enrollment.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I retire?

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage, which is described later in this section.

What types of coverage are available to my family and me?

Self-Only coverage is for you alone. *Self and Family* coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in another FEHB plan.

Section 8. FEHB facts *continued*

Are my medical and claims records confidential?

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

We will not refuse to cover the treatment of a condition that you or a family member had before you enrolled in this Plan solely because you had the condition before you enrolled.

When you lose benefits

What happens if my enrollment in this Plan ends?

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for former spouse coverage or Temporary Continuation of Coverage.

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

What is TCC?

Temporary Continuation of Coverage (TCC). If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees* from your employing or retirement office.

Section 8. FEHB facts *continued*

Key points about TCC:

- You can pick a new plan.
- If you leave Federal service, you can receive TCC for up to 18 months after you separate.
- If you no longer qualify as a family member, you can receive TCC for up to 36 months.
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce,
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event that qualifies them for coverage or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an individual policy if:

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you if individual coverage is available. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Section 8. FEHB facts *continued*

How can I get a Certificate of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health-related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months but were previously enrolled in other FEHB plans, you may request a certificate from them as well.

Department of Defense/FEHB Demonstration Project

What is the Department of Defense (DoD) and FEHB Program Demonstration Project?

The National Defense Authorization Act for 1999, Public Law 105-261, established the DoD/FEHBP Demonstration Project. It allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000. DoD and OPM have set up some special procedures to successfully implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible?

DoD determines who is eligible to enroll in FEHB. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare,
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare,
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried, or
- You are a survivor dependent of a deceased active or retired uniformed service member, and
- You live in one of the eight geographic demonstration areas.

If you are eligible to enroll in a Plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

Where are the demonstration areas?

- Dover AFB, DE
- Commonwealth of Puerto Rico
- Fort Knox, KY
- Greensboro/Winston Salem/High Point, NC
- Dallas, TX
- Humboldt County, CA
- Naval Hospital, Camp Pendleton, CA
- New Orleans, LA

Department of Defense/FEHB Demonstration Project *continued*

When can I join?

Your first opportunity to enroll will be during the 1999 Open Season, November 8, 1999, through December 13, 1999. Your coverage will begin January 1, 2000. DoD has set up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions, and forms. The toll-free phone number for the IPC is 877/DOD-FEHB, 877/363-3342.

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 1999, 2000, and 2001 Open Seasons. Your coverage will begin January 1 of the year following the Open Season that you enrolled.

If you become eligible for the DoD/FEHBP Demonstration Project outside of Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a website devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations, and zip code lists at **www.tricare.osd.mil/fehbp**. You can also view information about the Demonstration Project, including "The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project," on the OPM website at **www.opm.gov**.

Am I eligible for Temporary Continuation of Coverage (TCC)?

See Section 10, FEHB facts, for information about TCC. Under this Demonstration Project the only individual eligible for TCC is one who ceases to be eligible as a "member of family" under your Self and Family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHBP Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHBP Demonstration Project.

TCC is not available if you move out of a DoD/FEHBP Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Do I have the 31-Day Extension and Right to Convert?

These provisions do not apply to the DoD/FEHBP Demonstration Project.

Inspector General advisory: Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/759-0584 for Northern California Service Area and 800/464-4000 for Southern California Service Area and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

U.S. Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street, NW, Room 6400

Washington, D.C. 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Notes

Notes

Summary of benefits for Kaiser Foundation Health Plan, Inc., California Division—2000

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

Benefits		Plan pays/provides	Page
Inpatient care			
	Hospital	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital physician care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care, and complete maternity care. **You pay** nothing.	15
	Extended care	All necessary services, up to 100 days per benefit period. **You pay** nothing.	15
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 45 days of inpatient care per year. **You pay** nothing.	19
	Substance abuse	Covered under Mental Conditions Benefit	20
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups, and routine immunizations; laboratory tests and x-rays; complete maternity care. **You pay** $10 copayment per office visit and outpatient surgery visit.	12
	Home health care	All necessary visits by nurses and health aides. **You pay** nothing.	15
	Mental conditions	Up to 40 outpatient visits per calendar year. **You pay** a $5 copayment per individual visit; $5 per group therapy session.	19
	Substance abuse	Treatment and counseling visits. **You pay** a $5 copayment per individual visit; $2.00 per group therapy session. Mental conditions services are also covered as shown.	20
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** $35 copayment and all charges for non-covered benefits.	17
Prescription drugs		Drugs prescribed by your physician or dentist and obtained at a Plan pharmacy. **You pay** $5 per prescription unit or refill.	21
Dental care		No current benefit	
Vision care		Refractions. **You pay** a $10 copayment per visit.	22
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,500 per Self Only or $3,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copayment maximum does not include prescription drugs and other services listed on page 7.	7

2000 Rate Information for Kaiser Foundation Health Plan, Inc., California Division

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

Postal rates apply to most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Southern California									
Self Only	**621**	**$69.83**	**$23.27**	**$151.29**	**$50.43**	**$82.63**	**$10.47**	**$82.63**	**$10.47**
Self and Family	**622**	**$161.39**	**$53.79**	**$349.67**	**$116.55**	**$190.97**	**$24.21**	**$190.97**	**$24.21**
Northern California									
Self Only	**591**	**$65.00**	**$21.67**	**$140.84**	**$46.95**	**$76.92**	**$9.75**	**$76.92**	**$9.75**
Self and Family	**592**	**$155.18**	**$51.72**	**$336.21**	**$112.07**	**$183.62**	**$23.28**	**$183.62**	**$23.28**