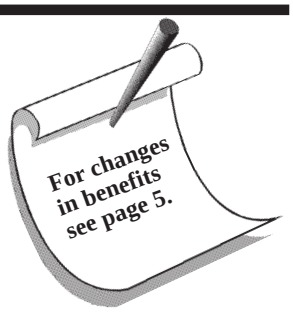
KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

2000

A Health Maintenance Organization



Serving: Portland and Salem, Oregon and Vancouver and Longview, Washington

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

Enrollment code:

571	High Option Self Only
572	High Option Self and Family
574	Standard Option Self Only
575	Standard Option Self and Family

For commercial HMO health plan. See the *2000 Guide* for more information on NCQA.

Joint Commission on Accreditation of Healthcare Organizations

This Plan has accreditation with commendation from the JCAHO. See the *2000 Guide* for more information on JCAHO.

Visit the OPM Web site at http://www.opm.gov/insure
and
this Plan's National Web site 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

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Introduction

Kaiser Foundation Health Plan of the Northwest
500 N.E. Multnomah St., Suite 100
Portland, OR 97232

This brochure describes the benefits you can receive from Kaiser Foundation Health Plan of the Northwest under its contract (CS1047) 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 of the Northwest 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 at a non-Plan facility, 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

Program-wide 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 provider 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, call Membership Services at 800/813-2000 ext. 315051. 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.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

Your share of the non-postal high option premium will increase by 4.9% for Self Only or 4.5% for Self and Family.

Your share of the non-postal standard option premium will increase by 5.9% for Self Only or 5.9% for Self and Family.

The primary care office visit copay will increase from $8 to $10 under the high option and from $10 to $12 under the standard option. (See page 10).

Self-referred chiropractic services will be covered for 20 visits per calendar year at a $15 copay per visit for high option and a $20 copay per visit for standard option. (See page 11).

Infertility treatment services will require a copayment of 50% of charges under both options. (See page 11).

Orthognathic surgery for temporomandibular joint dysfunction (TMD) will be covered if medical criteria are met subject to annual and lifetime benefit maximums. (See page 11).

Immunizations for travel will no longer be covered. (See page 11).

The benefit maximum for residential/day care facility treatment for substance abuse will increase from $3,000 every two calendar years to $3,500 for adults and $4,500 for children every two calendar years. (See page 15).

The copay for prescription drugs will increase from $8 to $10 under the high option and from $10 to $15 under standard option. (See page 16).

DME diabetic supplies (external insulin pumps, infusion devices, glucose monitors, and diabetic footcare appliances) will be covered under this Plan's Prescription Drug Benefit at a 50% copay. (See page 16).

Drugs for travel will no longer be covered. (See page 16).

The copay for a dental office visit will increase from $8 to $10. (See page 17).

Restorative dental services, such as routine fillings and simple extractions, will require a copayment of 50% of charges, instead of 20% of charges. (See page 17).

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 Oregon counties: Columbia, Multnomah, Polk, Yamhill.

And these Oregon zip codes:
Benton County: 97330, 97331, 97333, 97339, 97370;
Clackamas County: 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97055, 97067-68, 97070, 97080, 97222, 97267-68;
Linn County: 97321, 97335, 97355, 97358, 97374, 97389;
Marion County: 97002, 97020, 97026, 97032, 97071, 97137, 97301-3, 97305-14, 97325, 97352, 97359-60, 97362, 97373, 97375, 97381, 97383-85, 97392;
Washington County: 97005-8, 97062, 97075-78, 97106, 97109, 97113, 97116-17, 97119, 97123-25, 97133, 97140, 97144, 97223-25, 97229, 97291;

These Washington counties: Clark County

And these Washington zip codes:
Cowlitz County: 98581, 98603, 98609, 98611, 98625-26, 98632, 98645, 98649, 98674;
Lewis County: 98591, 98593, 98596;
Wahkiakum County: 98612, 98647.

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 most 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 13; and for emergency care obtained from any non-Plan provider, as described on page 14. We will not pay for any other health care services if received from non-Plan providers without prior authorization.

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 Enrollment to change plans. Contact your employing 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 $6. This charge will be added to each bill sent for services not paid.

After you pay $600 in copayments or coinsurance for one family member, or $1,200 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 outpatient prescription drugs, contraceptive devices, dental services, outpatient mental health services beyond the first 20 covered visits, corrective appliances and artificial aids, durable medical equipment, the $25 charges paid for follow-up or continuing care, and long-term physical therapy and rehabilitation, under both the High Option and Standard Option, 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 health care at Plan medical centers, medical offices, and dental care at dental offices conveniently located throughout the Portland, Vancouver, Salem, and Longview-Kelso areas.

The Plan contracts with Northwest Permanente, P.C., Physicians and Surgeons, an independent multi-specialty group of physicians, to provide or arrange all necessary physician care for Plan members. Permanente Dental Associates, an independent group of dentists, provides or arranges dental care for members of the High Option plan.

Plan physicians, nurse practitioners, physician assistants, and other skilled medical personnel working as medical teams provide your health care services. Specialists consult with these medical teams in determining your treatment. Plan physicians refer patients to community specialists when necessary. Other services, such as physical therapy and laboratory and X-ray, are available at Plan facilities. Inpatient care is available at Kaiser Sunnyside Medical Center, Providence St. Vincent Medical Center, Providence Portland Medical Center, Southwest Washington Medical Center, Salem Hospital, St. John Medical Center, Doernbecher Children's Hospital (for children only), and Legacy Emanuel Hospital and Health Center (for low risk childbirth services). Check this Plan's Medical Directory for additional information on the location and services provided at each hospital.

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 from 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.

Your primary care physician (PCP)—either a family practitioner, pediatrician, 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. If you are referred to a community provider, the Plan must approve the referral. However, a woman may see her obstetrician/gynecologist without having to obtain a referral. You may also receive outpatient alcohol and drug treatment, cancer counseling, eye examination, outpatient mental health, occupational health, and social work services without a referral.

Choose your primary care physician from this Plan's provider directory. The directory, which is updated on a regular basis, lists primary care physicians (generally family practitioners, pediatricians, and internists) with their locations and phone numbers. A Medical Directory will be sent to you after you enroll or you may obtain one by calling the Membership Services department at 503/813-2000 or 800/813-2000.

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 supervise your care.

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

First, call our Membership Services department at 503/813-2000 or 800/813-2000. 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?

Call the appointment desk of your medical office during office hours to schedule routine appointments in the following specialty departments: outpatient alcohol and drug treatment, cancer counseling, contact lenses, eye examinations, outpatient mental health, obstetrical/gynecology, occupational health, and social work.

Your primary care physician will determine if you need care from other Plan specialists. Most specialty care is provided by physicians within the Plan. If your primary care physician refers you to a specialist in the community, he or she will obtain necessary authorizations from the Plan. 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 must review the recommendation and authorize the visits or services, if appropriate. You may go to a community specialist only when 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 until you have received the specified number of visits. Contact your primary care physician if you need additional care. Your primary care physician will obtain Plan authorization for these visits.

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.

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 provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before referring you to a community specialist. Before giving approval, 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) it 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 or Dental Group carefully evaluate whether a particular therapy is safe and effective or offers a reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental 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 503/813-2000 or 800/813-2000 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 did 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.

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.

Where should I mail my disputed claim to?

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

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.

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?

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

What is covered

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.

High Option
You pay $10 per visit

Standard Option
You pay $12 per visit

for the following services:

- Preventive care, including well-baby care 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 at no charge. In addition to routine screening, mammograms are covered when prescribed by the physician as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters at no charge
- Allergy testing and treatment, including test and treatment materials (such as allergy serum)
- Visits to receive injections
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays at no charge
- Complete obstetrical (maternity) care for all covered females, prenatal, delivery, and postnatal care by a Plan physician. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Cornea, heart, heart-lung, kidney, simultaneous pancreas-kidney, liver, and lung (single and double) transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors. Related medical and hospital expenses of the donor are covered.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis (office visit charges will be waived if you enroll in Medicare Part B and assign your Medicare benefits to the Plan)
- Chemotherapy, respiratory therapy, and radiation therapy
- Cardiac rehabilitation following a heart transplant, bypass surgery, or myocardial infarction
- Surgical treatment of morbid obesity
- For homebound members residing in the service area, home health services of nurses and health aides, physical or occupational therapists, and speech and language pathologists, when prescribed by your Plan physician, who will periodically review the program for continuing appropriateness and need at no charge.
- Medical management of mental health conditions, including drug therapy evaluation and maintenance
- Services of physicians and other health professional in the hospital or extended care facility

If you do not pay any of the charges required for the services at the time you receive the services, you will be billed. You will also be required to pay a $6 charge for each bill sent for unpaid services.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including 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 inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months; **you pay** $10 per outpatient session under the High Option and $12 per outpatient session under the Standard Option; and nothing for an inpatient session. Speech and language services are 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 per lifetime; **you pay** nothing.

Diagnosis and treatment of infertility is covered; for diagnosis, **you pay** $10 per outpatient session (High Option) and $12 per outpatient session (Standard Option); for treatment, **you pay** 50% of charges (Standard and High Option). Artificial intrauterine insemination (IUI) is covered, **you pay** 50% of charges (Standard and High Option). Intravaginal insemination (IVI) and intracervical insemination (ICI) are not covered. Cost of donor sperm and donor eggs and services related to their procurement and storage are not covered. Other assisted reproductive technology (ART) procedures that enable a woman with otherwise untreatable infertility to become pregnant through other artificial conception procedures such as in vitro fertilization, gamete and zygote intrafallopian transfers are not covered. Infertility services are not available when either member of the family has been voluntarily surgically sterilized. Drugs used in the treatment of infertility are not covered.

Prosthetic devices to restore or manage head and facial structures that are defective will be provided; **you pay** 20% of charges. Breast prostheses, surgical bras, and their replacements are covered at no charge. Devices used primarily for cosmetic purposes that are not necessary to control or eliminate infection, pain, or restore functions such as speech, swallowing, or chewing are not covered. Artificial larynxes, voice machines, artificial hearts, internally implanted insulin pumps, penile prosthetic devices, dentures, and devices to treat temporomandibular joint conditions are not covered.

Orthognathic surgery for temporomandibular joint dysfunction (TMD) will be covered if medical criteria are met, subject to an annual benefit maximum of $1,000, and a lifetime benefit maximum of $5,000. **You pay** 100% of charges after benefit maximum is reached.

Self-Referred Chiropractic services. Up to 20 visits per calendar year of self-referred chiropractic services provided by Participating Chiropractors. Covered services include evaluation and management, musculoskeletal treatments, physical therapy modalities such as hot and cold packs, and X-rays. **You pay** $15 per visit for the High Option; $20 per visit for the Standard Option. The following are not covered: non-neuroskeletal disorders; vocational rehabilitation services; laboratory services; MRI or other type of advanced diagnostic radiology; and durable medical equipment or supplies for use in the home.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- External and internally implanted hearing aids
- Homemaker services
- Long-term rehabilitative and cognitive 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.
- Orthopedic devices including foot orthotics
- Durable medical equipment, such as wheelchairs and hospital beds
- Devices, equipment, supplies, and prosthetics related to the treatment of sexual dysfunction
- Travel immunizations
- Medications related to foreign travel

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
- If determined to be medically necessary by the attending Plan physician, members hospitalized for medical (non-psychiatric) conditions will be provided all necessary inpatient psychiatric consultations. This inpatient consultation benefit is in addition to the mental conditions benefits shown on page 15.

Extended Care

The Plan provides a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is in lieu of hospitalization. **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 or a Plan approved hospice facility. **You pay** nothing. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan 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** $25 per transport.

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 15 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care or care in an intermediate care facility
- Collection, processing, and storage of blood donated by donors designated by you or a family member. Costs associated with blood donated by you for a scheduled covered surgery are covered.

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

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

If you plan to travel to an area with another Kaiser Permanente plan and wish to obtain more information about the benefits available to you from that Kaiser Permanente Plan, please call Membership Services at 503/813-2000 or 800/813-2000.

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 Benefits 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, as you would an emergency claim. Claims should be submitted to Claims Department, Kaiser Foundation Health Plan of the Northwest, 500 N.E. Multnomah Street, Suite 100, Portland, Oregon 97232. If the services are covered under this Travel Benefit, you will be reimbursed the usual and customary 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 the 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

In a life threatening emergency—call the local emergency system (e.g., the local 911 telephone system). When the operator answers, stay on the phone and answer all questions. If an ambulance comes, tell the paramedics that the person who needs help is a Kaiser Permanente member. You or a family member must notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been notified.

For other serious conditions—go to the emergency department at a Plan facility—a Kaiser Permanente hospital or a designated plan hospital or a participating Group Health facility—unless the time it would take to do so would result in serious medical consequences. If that is the case, go to the nearest hospital.

If you are admitted to a non-Plan facility, call the Patient Transfer Coordinator at 503/813-4540 or 800/813-2000 and ask for the Patient Transfer Coordinator. You must call 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 physicians believe your care can be better provided in a Plan facility, you will be transferred when medically feasible.

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.

At Plan facilities

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

You pay...$25 per visit plus any charges which would have been required if the care had been rendered by the Plan. If the visit results in an inpatient admission, you pay only the office visit charge.

At non-Plan hospitals

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

You pay...50% of the first $100 plus any charges which would have been required if care had been rendered by the Plan.

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 available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling the Membership Services department at 503/813-2000 or 800/813-2000.

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan physician believes care can be better provided in a Plan hospital, you will be transferred when medically feasible.

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

You pay...50% of the first $100, plus any charges which would have been required if the care had been rendered by the Plan.

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. You should submit claim forms to Claims Department, Kaiser Foundation Health Plan of the Northwest, 500 N.E. Multnomah Street, Suite 100, Portland, Oregon 97232. 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 8.

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 treatment
- Hospitalization (including inpatient professional services)

Outpatient Care

Up to 40 outpatient visits to Plan physicians, consultants, or other psychiatric personnel every two calendar years.

High Option	Standard Option
You pay $5 per visit for visits 1–40	**You pay** $10 per visit for visits 1–40

Under both options, you pay 50% of charges for all visits following the 40th visit.

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

Inpatient Care

Both Options. Up to 60 days of hospitalization every two calendar years; **You pay** nothing for the first 60 days—50% of charges thereafter.

Residental/ Day Care Facility

Both Options. All necessary treatment up to 29 days every two calendar years. **You pay** $50 per day up to a maximum of $250 per admission.

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

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 or condition. In addition, the Plan provides:

Outpatient Care

Dependency counseling

High Option	Standard Option
You pay $5 per visit	**You pay** $8 per visit

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

Residential/ Day Care Facility

All necessary treatment up to a maximum benefit paid by the Plan of $3,500 for adults and $4,500 for children every two calendar years. **You pay** 20% of charges for covered services—both options.

What is not covered

- Treatment which is not authorized by a Plan physician

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor or any licensed dentist and obtained at a Plan pharmacy will be dispensed for up to a 30 day supply or 100 dosage units for oral solids or one pint for oral liquid medications, or if obtained through the mail order pharmacy will be dispensed for up to a 90 day supply for oral solids or one point for oral liquid medications. **You pay** $10 (High Option) or $15 (Standard Option) per prescription or refill.

You may receive refills by mail at no extra charge and there is no additional charge for delivery. Ask for details at a Plan pharmacy.

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

The following drugs are drugs provided at the $10 (High Option) or $15 (Standard Option) charge (unless another charge is specifically identified):

- Drugs for which a prescription is required by law
- Oral contraceptive drugs (dispensed in 90 days supply); **you pay** $10 (High Option) or $15 (Standard Option) per prescription per 30-day supply; contraceptive devices, such as diaphragms, intrauterine devices, and cervical caps; **you pay** $10 (High Option) or $15 (Standard Option) times the number of months the device is expected to be effective
- Implanted time release drugs. **You pay** $10 (High Option) or $15 (Standard Option) times the expected number of months the medication will be effective. There will be no refund if the implanted drug is removed before the end of its expected life
- Injectable contraceptives. **You pay** $10 (High Option) or $15 (Standard Option) per prescription times the expected number of months the medication will be effective
- Insulin
- Glucose test strips
- Smoking cessation drugs and medication, including prescribed nicotine gum and patches, when used in conjunction with smoking cessation programs
- Chemotherapy
- Certain over-the-counter medications which are prescribed by a Plan physician and listed on the Plan's formulary as the most appropriate treatment for a particular condition
- Prescription drugs for a dental condition as listed in the Plan's dental drug formulary
- Disposable needles and syringes needed to inject covered prescribed medication
- DME diabetic supplies such as external insulin pumps, infusion devices, glucose monitors, and diabetic footcare appliances. **You pay** 50% of charges.

The following are provided at no charge:

- Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU)
- Immunosuppressive drugs required after a transplant
- Intravenous fluids and medication for home

Limited benefits

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

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available, except those listed on the Plan's formulary and prescribed by a Plan physician
- 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 for the treatment of infertility
- Drugs related to non-covered services
- Drugs used in weight management
- Drugs for foreign travel

Other benefits

Dental Care— High Option only

What is covered

For members who have elected the High Option Plan, a comprehensive range of dental services (as described below) are covered when prescribed by Plan dentists and provided at Plan dental offices.

Office Visits—You pay $10 for each office visit.

Diagnostic Services and Preventive Care—You pay $10 per visit for routine oral examinations and X-rays; oral prophylaxis (routine teeth cleaning) including topical application of fluoride, when prescribed by a Plan dentist, but not more than two visits in any twelve consecutive months; prescribed space maintainers and habit appliances.

Restorative Services—You pay $10 per visit plus 50% of charges for restorative services, including routine fillings, local anesthesia, stainless steel or plastic crowns, and simple extractions.

Oral Surgery—You pay $10 per visit plus 50% of the charges for diagnosis, evaluation, consultation, and treatment for removal of teeth (including local anesthesia), minor surgical preparation of mouth for insertion of dentures, and surgical treatment normally performed by a dentist for minor pathological conditions.

Periodontics—You pay $10 per visit plus 50% of the charges for diagnosis, evaluation, consultation, and treatment for periodontics (diseases of tissues supporting the teeth), including all follow-up cleaning visits.

Endodontics—You pay $10 per visit plus 50% of the charges for diagnosis, evaluation, consultation, and treatment for endodontics (root canal therapy).

Prosthetics—You pay $10 per visit plus 50% of the charges for diagnosis, evaluation, consultation, and treatment for prosthetics, including full or partial dentures, gold or porcelain crowns, inlays, or bridge pontics. There will be an additional charge for the use of precious metals if a clinically acceptable non-precious metal alternative material is available and prescribed by a Plan dentist.

After Hours Care—You pay an additional $25 per visit for any dental care received from a Plan dentist after Plan dental hours or on weekends, except for prescheduled appointments.

Out-of-Area Emergency Care—The Plan pays up to $100 for emergency care for relief of pain, acute infection, or hemorrhage, or necessary treatment (including local anesthesia and premedication) due to injury. You pay all charges exceeding $100.

Prescription Drugs—Covered under Prescription Drug Benefits. See page 16.

Nitrous Oxide—You pay $15 per occurrence, except children 12 years of age and under pay nothing for the service.

Accidental Injury Benefit—You pay $10 per visit for restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from accidental injury.

What is not covered

- Orthodontics
- Treatment for problems of the jaw joint, including temporomandibular joint syndrome/ craniomandibular disorders; or other conditions of the joint linking the jaw bone and skull, and of the complex of muscles, nerves, and other tissues related to that joint (See Medical and Surgical Benefits page 10 for coverage.)
- Dental implants, including bone augmentation and the fixed or removable prosthetic devices attached to or covering the implants; and all services and materials relating to the placement or removal of implants including, but not limited to, diagnostic consultations, impressions, oral surgery, and removal of implants for cleaning; and services related to post-operative conditions or complications arising from implants
- Restorative or reconstructive services for congenital or developmental malformations
- Full mouth reconstructions. This includes appliances, restoration, and procedures needed to alter vertical dimension or occlusion, or in conjunction with alteration of vertical dimension or occlusion or for the purpose of splinting teeth or correcting attrition or abrasion.
- Cosmetic dental services
- Restoration replacement. Clinically acceptable restorations or material will not be removed or replaced with alternative materials unless a pathological condition of the teeth exists
- Missed appointments; you pay $10 for each appointment missed, unless the Plan dental office is notified in advance
- IV sedation
- Genetic testing

Vision Care

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, this Plan provides vision care benefits to members when prescribed by Plan physicians or optometrists and provided at Plan facilities and optical departments.

What is covered

Refractions—You pay $10 per visit High Option and $12 per visit Standard Option for eye exams for eyeglasses and contact lenses.

Eyeglasses and contact lenses—when prescribed by a Plan physician or optometrist.

High Option—One pair of eyeglasses (regular lenses and designated frames), medically indicated contact lenses, or designated industrial safety glasses from the Plan's Optical department is provided at no charge once every two years since last provided by the Plan. If a significant change in correction occurs in one or both eyes before the two years has elapsed, lenses with the new correction are provided at no charge. If you select non-medically indicated contact lenses or eyeglasses which cost more than regular lenses and designated frames, you pay charges, less a credit equal to the cost of the regular designated eyeglasses.

Standard Option—You receive a credit of $25 toward the purchase of eyeglasses, contact lenses, or industrial safety glasses from the Plan's Optical department once every two years since last provided by the Plan. The $25 credit will apply also toward post cataract surgery benefits described below. If a significant change in correction in one or both eyes occurs before the two year period has elapsed, an additional $25 credit will apply toward the purchase of lenses with the new correction.

Medically Indicated Contact lenses

Medically indicated contact lenses as described under the High/Standard Options above will be provided at no charge under the High Option and at a credit of $25 under the Standard Option for:

- Post cataract surgery
- Extremely high degrees of near or far-sightedness
- Distorted corneas which limit the best visual acuity with glasses
- Visual errors of the two eyes which are greatly different in power

Post-Cataract Surgery

Post-cataract surgery patients will be provided the following items at no charge under the High Option and included as part of the $25 credit under the Standard Option:

- One pair of regular lenses and designated frames; or
- One pair of contact lenses and one pair of designated frames and reading lenses, if both must be worn at the same time to provide a significant improvement in visual acuity
- Medically necessary intraocular lenses (at no charge for both Options)

What is not covered

- Sunglasses, prescription or plain
- Athletic safety glasses
- Photogrey, photosun, and tinted lenses
- Two pairs of lenses and frames in lieu of bifocals in the same frames
- Repair or replacement of broken, lost, or stolen lenses or frames
- Contact lenses having no refractive value
- Fitting and routine follow-up services for non-medically indicated contact lenses
- Visual training
- Refractions for non-medically indicated contact lenses
- Vision therapy (orthoptics or eye exercises)

Special Benefits for Medicare Eligible Enrollees

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

The Senior Advantage Program Plan provides all Medicare covered Part A and Part B benefits to the Medicare beneficiary, as well as some benefits not covered by Medicare. It is an arrangement between Medicare and this Plan in which Medicare pays a specific amount to this plan for each Medicare beneficiary who enrollees 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 A Guide to Your Kaiser Permanente Senior Advantage Benefits. For a copy of these rules, please contact Membership Services at 503/813-2000 or 800/813-2000.

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

Classes to change your lifestyle and keep you healthy

At Kaiser Permanente, we actively encourage you to share responsibility for your health care.

Choices you make every day, about what you eat and drink, whether you exercise or smoke, how you handle stress, or whether you wear a seat belt, are tied directly to your health. They affect your chances of having a stroke or a heart attack, getting cancer, or being at risk for handicapping injuries.

We have developed a wide range of health education and health promotion classes to help you stay healthy. You can learn how to kick the smoking habit for good, effectively manage your weight, improve personal and family relationships, deal more effectively with a chronic health problem, have a safe and healthy pregnancy, and much more. Descriptions of the **Freedom From Cigarettes** and **Freedom From Fat** classes are shown below. Over 40 other classes are also offered. Class fees begin as low as $3 per member for some classes.

Our classes are open to everyone, but we offer them at special reduced rates to our members. If you would like to enroll, you must fill out a registration form. For the latest class catalog, call:

Health Education
Portland.....503/286-6816
8 a.m.–5 p.m., Monday–Friday
Salem.....503/316-2344
Washington.....360/604-2070

Membership Services
Portland.....503/813-2000
8 a.m.–7 p.m., Monday–Friday
All other areas.....800/813-2000
8 a.m.–7 p.m., Monday–Friday

Freedom from Fat

A 16 week program divided into two 8 week series: “Getting Started and Moving On,” plus the optional follow-up program called “On-going Progress.”

Are you tired of losing weight just to gain it back? Do you want to learn to eat low-fat foods to keep your cholesterol level safe? The **Freedom From Fat** program can help you manage your low-fat lifestyle for good. That’s because **Freedom From Fat** is more than a diet program. It is a new approach to eating developed by researchers at Kaiser Permanente. The classes are conducted by professional nutrition and behavior change specialists. Each meeting provides a format for problem-solving discussion.

Series I: Getting Started (Eight 2 hour sessions)
Series II: Moving On (Eight 2 hour sessions)
Ongoing program follow-up: (Twelve 1.5 hour sessions)

Freedom From Cigarettes

The “cold turkey” approach to stop smoking or chewing tobacco.

Learn the latest and most effective techniques for kicking the smoking habit for good. Sessions include:
- Relaxation techniques
- Understanding cigarette addiction
- Practicing effective ways to remain a non-smoker

Six 1-1/2 hour classes

Freedom from Cigarettes with Temporary Drug Therapy

Ten 1+ hour sessions

These classes are designed to provide you with techniques and support that will increase your chances for lifelong freedom from tobacco.

To be eligible for **Freedom from Cigarettes with Drug Therapy** the participants must:
- Have made repeated attempts to quit tobacco use on his/her own; and
- Be medically appropriate

Drug therapy has been proven to be most successful when used in conjunction with a behavior change program. The medication treatment is a short term aid for people committed to learning how to stop smoking or chewing, and who have been unsuccessful with other methods.

Your present pharmacy benefit provides coverage for smoking cessation drugs, nicotine gum and patches when used in conjunction with this program.

Sessions from both **Freedom From Cigarettes** and **Freedom from Fat** provide a free, no obligation, 1-hour Explanatory Session (no registration needed). Call 503/286-6880 (message recorder) and leave your name, address and phone number. We will send you class dates, times, and locations.

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 Enrollment.

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, see page 19.

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.

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.

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 Web site 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 503/813-2000 or 800/813-2000, or write to Kaiser Permanente, Membership Services, 5115 N. Greeley Avenue, Portland, Oregon 97217. You may also contact us by fax at 503/735-2706, or visit our Web site at http://www.kaiserpermanente.org or by e-mail at Membership Services at www.kaiserpermanente.org/locations/northwest.

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 Enrollment 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 for 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 step children 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.

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.

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, which 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.

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.

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 503/813-2000 or 800/813-2000 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.

Summary of Benefits for Kaiser Foundation Health Plan of the Northwest—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, COVERED FOLLOW-UP AND CONTINUING CARE SERVICES, AND CARE RECEIVED FROM OTHER KAISER PERMANENTE PLANS, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN PHYSICIANS.**

Benefits		High Option 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	12
	Extended Care	All necessary services, for up to 100 days per calendar year. **You pay** nothing	12
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 60 days of inpatient care every two calendar years. **You pay** nothing for first 60 days, 50% of charges thereafter; all necessary residential/day care treatment up to 29 days every two calendar years. **You pay** $50 per day up to a maximum of $250 per admission	15
	Substance Abuse	Treatment services up to $3,500 for adults and $4,500 for children benefit maximum every two calendar years. **You pay** 20% of charges. Mental conditions benefits are also covered as shown	15
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 per office, outpatient surgery, or physician's home visit	10
	Self-Referred Chiropractic Services	**You pay** $15 per visit, up to 20 visits per year	11
	Home Health Services	All necessary visits by nurses and health aides, physical or occupational therapists, and speech and language pathologists. **You pay** nothing	10
	Mental Conditions	Up to 40 outpatient visits every two calendar years. **You pay** $5 per outpatient visit; 50% of charges thereafter	15
	Substance Abuse	Short-term counseling. **You pay** $5 per office visit. Mental conditions benefits are also covered as shown	15
	Emergency Care	Usual and customary charges for services and supplies required because of a medical emergency. **You pay** $25 per visit for in-Plan emergency care plus any charges which would have been required if the care had been rendered by the Plan. If the visit results in an inpatient admission, you pay only the office visit charge. **You pay** 50% of the first $100 in charges for non-Plan for emergency care, applicable Plan copayments, and any charges for services that are not covered by this Plan	13
	Prescription Drugs	Drugs prescribed by a Plan physician and obtained at a Plan pharmacy. **You pay** $10 per prescription unit or refill	16
	Dental Care	Preventive dental care; comprehensive range of restorative, and other services. **You pay** $10 per office visit; 50% of charges for restorative services and simple extractions; 50% of charges for certain other services	17
	Vision Care	Covered refractions. **You pay** $10 per visit. One pair of eyeglasses, medically necessary contact lenses, or industrial safety glasses as shown every two years. **You pay** nothing	18
	Out-of-Pocket Maximum	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $600 per Self Only or $1,200 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%	6

Summary of Benefits for Kaiser Foundation Health Plan of the Northwest—2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated, subject to the definitions, 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, COVERED FOLLOW-UP AND CONTINUING CARE SERVICES, AND CARE RECEIVED FROM OTHER KAISER PERMANENTE PLANS, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN PHYSICIANS.**

Benefits		Standard Option pays/provides	Page
Inpatient Care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital 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	12
	Extended Care	All necessary services for up to 100 days per calendar year. **You pay** nothing	12
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 60 days of inpatient care every two calendar years. **You pay** nothing for first 60 days, 50% of charges thereafter; all necessary residential/day care treatment up to 29 days every two calendar years. **You pay** $50 per day up to a maximum of $250 per admission	15
	Substance Abuse	Treatment services up to a $3,500 for adults and $4,500 for children benefit maximum every two calendar years. **You pay** 20% of charges. Mental conditions benefits are also covered as shown	15
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** $12 per office, outpatient surgery, or physician's home visit	10
	Self-Referred Chiropractic Services	**You pay** $20 per visit, up to 20 visits per year	11
	Home Health Services	All necessary visits by nurses and health aides, physical or occupational therapists, and speech and language pathologists. **You pay** nothing	10
	Mental Conditions	Up to 40 outpatient visits every two calendar years. **You pay** $10 per outpatient visit; 50% of charges thereafter	15
	Substance Abuse	Short-term counseling. **You pay** $8 per office visit. Mental conditions benefits are also covered as shown	15
	Emergency Care	Usual and customary charges for services required because of a medical emergency. **You pay** $25 per visit for in-Plan emergency care plus any charges which would have been required if the care had been rendered by the Plan. If the visit results in an inpatient admission, you pay only the office visit charge. **You pay** 50% of the first $100 in charges for non-Plan for emergency care, applicable Plan copayments, and any charges for services that are not covered by this Plan	13
	Prescription Drugs	Drugs prescribed by a Plan physician and obtained at a Plan pharmacy. **You pay** $15 per prescription unit or refill	16
	Dental Care	No current benefit.	
	Vision Care	Covered refractions. **You pay** $12 per visit. You receive a $25 credit toward the purchase of a pair of eyeglasses, contact lenses, or industrial safety glasses every two years. **You pay** any amount above the credit	18
	Out-of-Pocket Maximum	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $600 per Self Only or $1,200 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%	6

2000 Rate Information for
Kaiser Foundation Health Plan of the Northwest

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 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**
High Option Self Only	**571**	**$78.83**	**$29.74**	**$170.80**	**$64.44**	**$93.06**	**$15.51**	**$93.26**	**$15.31**
High Option Self and Family	**572**	**$175.97**	**$73.19**	**$381.27**	**$158.58**	**$207.74**	**$41.42**	**$201.02**	**$48.14**
Standard Option Self Only	**574**	**$66.67**	**$22.22**	**$144.45**	**$48.15**	**$78.89**	**$10.00**	**$78.89**	**$10.00**
Standard Option Self and Family	**575**	**$153.00**	**$51.00**	**$331.50**	**$110.50**	**$181.05**	**$22.95**	**$181.05**	**$22.95**