



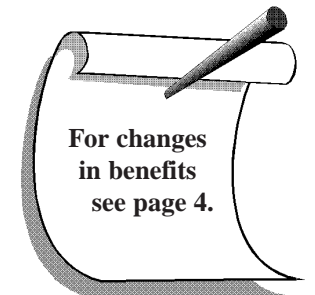
# Kaiser Foundation Health Plan of Ohio

2000

## A Health Maintenance Organization

**Serving:** Cleveland and Akron, Ohio Metropolitan Areas

Enrollment in this Plan is limited; see page 4 for requirements.



**Enrollment code:**  
641 Self Only  
642 Self and Family



This Plan has commendable accreditation –  
(formerly called full accreditation)  
from the NCQA. See the *FEHB Guide*  
for more information on NCQA.

Visit the OPM website at <http://www.opm.gov/insure>  
and  
our National website at <http://www.kaiserpermanente.org>

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United States Office of  
Personnel Management  
Retirement and Insurance Service



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## **Introduction**

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Kaiser Foundation Health Plan of Ohio  
North Point Tower  
1001 Lakeside Avenue  
Cleveland, Ohio 44114

This brochure describes the benefits you can receive from Kaiser Foundation Health Plan of Ohio under its contract (CS 1182) 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 4. Premiums are listed at the end of this brochure.

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## **Plain language**

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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 Ohio 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

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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.

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## Section 1. Health Maintenance Organizations

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

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

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

## Section 2. How we change for 2000

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### 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 leaves the FEHB Program. (See Section 3, How to get benefits, for more information.)

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

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 premium will increase by 5.3% for Self Only or 12.3% for Self and Family.

The primary care office visit copay will increase from \$5 to \$10. (See page 10.).

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## Section 3. How to get benefits

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### What is this Plan's service area?

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

These counties in the Cleveland, Ohio metropolitan area:  
Cuyahoga, Geauga, Lake, Lorain and Medina.

These counties in the Akron, Ohio metropolitan area:  
Portage, Stark, Summit and Wayne.

Ordinarily, you must receive your care from physicians, hospitals and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente service area, you can receive virtually all of the benefits of this Plan at any other Kaiser Permanente facility. We also pay for certain follow-up services, or continuing care services while you are traveling outside the service area, as described on page 14; and for emergency care obtained from any non-Plan provider, as described on page 15. We will not pay for any other health care services.

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

### **Section 3. How to get benefits** *continued*

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#### **How much do I pay for services?**

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

After you pay \$4,052 in copayments or coinsurance for one family member, or \$12,156 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 prescription drugs or devices, the \$25 charge for follow-up or continuing care, outpatient mental health services beyond the 20th visit, inpatient mental health copayments, if any, reconstructive surgery, durable medical equipment, prosthetic devices, orthotic appliances and CORF (Comprehensive Outpatient Rehabilitation Facility) services 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 facilities conveniently located throughout the Cleveland and Akron metropolitan areas and through referral specialists, hospitals and other providers in the community. Health Plan contracts with the Ohio Permanente Medical Group, an independent multi-specialty group of more than 290 physicians ("Plan physicians"), to provide or arrange all necessary physician care for Plan members. These Plan physicians are members of American Specialty Boards or are Board eligible. 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 laboratory and X-ray, are available at Plan facilities and other designated locations. Hospital care is available through the Plan at several local community hospitals.

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. However, a woman may see her Plan obstetrician or Plan gynecologist without having to obtain a referral. You may also receive services for routine eye refractions, outpatient mental health, and outpatient alcohol and chemical dependency without a referral.

Choose your primary care physician from this Plan's provider directory. The directory, which is updated on a regular basis, lists the physicians' addresses, phone numbers, and lets you know whether the physician is accepting new patients. To get a directory, call our Customer Relations Representatives at 216/621-7100 or toll-free at 800/686-7100 from anywhere within the United States. If you want to receive care from a specific physician who is listed in the directory, call the Customer Relations Department to verify that he or she still participates with the Plan and is accepting new patients.

### **Section 3. How to get benefits** *continued*

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**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?**

Talk to your primary care physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

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

First, call our Customer Relations Representatives at 216/621-7100 or at 800/686-7100. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

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

These provisions only apply to the person who is hospitalized.

**How do I get specialty care?**

Your primary care physician will determine if you need care from a specialist. He or she will obtain necessary authorizations from the Plan. The referral will describe either a specific service, a treatment or series of treatments, or be limited to a specific period of time. You should return to your primary care physician after your consultation with the specialist. If your specialist recommends additional visits or services, your primary care physician will review the recommendation and authorize the visits or services, as appropriate. You should not go to a specialist unless your primary care physician and your Plan has 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. 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.

### **Section 3. How to get benefits** *continued*

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**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 until the end of your postpartum care.

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

**How do you authorize medical services?**

Your primary care physician or specialist must obtain a precertification that the proposed treatment is a covered benefit and that the service is medically necessary to prevent, diagnose or treat an illness or condition, before sending you to a hospital, referring you to a specialist, or recommending follow-up care. 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 carefully evaluate whether a particular therapy is safe and effective or offers a degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical literature.



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

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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 216/621-7100 or at 800/686-7100 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 8:00 a.m. and 5:00 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.

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

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### **What do I send to OPM?**

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

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

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

### **Who can make the request?**

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

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

### **Where should I mail my disputed claim to?**

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

### **What if OPM upholds the Plan's denial?**

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

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

### **What laws apply if I file a lawsuit?**

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

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

### **Your records and the Privacy Act**

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

## Section 5. Benefits

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### 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; **you pay** a \$10 office visit copay, but no additional copay for laboratory test and X-rays. Within the service area, house calls will be provided if in the judgement of the Plan physician such care is necessary and appropriate; **you pay** a \$10 copay for a physician's house call for the first two calls only in any illness and nothing for home visits by other health professionals.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups.
- Mammograms are covered as follows: for women age 35 through 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 and above one mammogram every year. 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.
- Consultations by specialist.
- Diagnostic procedures, such as laboratory tests and X-rays.
- Complete obstetrical (maternity) care for covered females including prenatal visits, delivery and postnatal care by a Plan physician. Copays for prenatal office visits are waived. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn 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.
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum).
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung (single or double), and pancreas transplants; allogenic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Transplants are covered when approved by the Medical Group. Related medical and hospital expenses of the donor are covered.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis (office visit charges will be waived if you enroll in Medicare Part B and assign your Medicare benefits to the Plan).
- Chemotherapy, radiation therapy, and respiratory therapy.
- Surgical treatment of morbid obesity.
- Blood and blood products and the administration of blood.
- For homebound members residing in the service area, home health services of health professionals, including intravenous fluids and medications, when prescribed by your Plan physician, who will periodically review the program for continuing appropriateness and need.

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS**

## Section 5. Benefits *continued*

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- Visits to receive injections.
- Medical management of mental health conditions, including drug therapy evaluation and maintenance.
- All necessary medical or surgical care in a hospital or extended care facility from Plan physicians and other Plan providers, at no additional cost to you.

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

### Limited Benefits

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

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

**Short-term rehabilitative therapy** (physical, speech, and occupational) is provided on an outpatient basis for up to two consecutive months or 30 visits, whichever is greater, per condition if significant improvement can be expected within two months or 30 visits; **you pay** \$10 per visit. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

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

**Durable medical equipment** is provided under Plan criteria as of January 1 of the prior year for home use, on a rental or purchase basis, at the Plan's discretion, and obtained from sources designated by the Plan, for use by the member during the period it is used as prescribed, including repair and replacements other than those necessitated by misuse or loss. **You pay** nothing. The following items are not covered: electronic monitors of the function of the heart or lungs (except apnea monitors for newborns), and devices to perform medical tests on blood or other bodily substances or excretions (except blood glucose monitors for insulin dependent diabetics); modification to the home or auto, exercise and hygienic equipment, experimental or research equipment, self-help devices not primarily medical in nature, and physician's equipment.

**Diagnosis and treatment of infertility** is covered. **You pay** 30% of charges. The following type of artificial insemination is covered: intrauterine insemination (IUI); **you pay** 30% of charges. Services related to in-vitro fertilization, ovum transplants, gamete and zygote intrafallopian tube transfers, the procurement and storage of donor eggs, services that are experimental or investigational, procedures for women who have evidence of ovarian failure, and services for surrogate mothers who are not Plan members are not covered. Infertility services are not available when either member of the family has been voluntarily surgically sterilized. Drugs related to non-covered infertility services are not covered. All prescribed drugs administered for the further evaluation or treatment of infertility are covered; **you pay** 50% of charges.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

## Section 5. Benefits *continued*

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**External prosthetic and orthotic devices and braces** are provided under Plan criteria as of January 1 of the prior year when prescribed by a Plan physician and obtained from sources designated by the Plan, including replacements, repair and adjustments other than those necessitated by misuse or loss. **You pay** nothing.

### What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance or governmental licensing
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- External and internally implanted hearing aids
- Homemaker services
- Chiropractic services
- Autologous or donor directed blood and related cost
- Long-term rehabilitative therapy
- Transplants not listed as covered
- Cardiac rehabilitation following a heart transplant, bypass surgery or myocardial infarction
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism
- Devices, equipment, supplies and prosthetics related to the treatment of sexual dysfunction

## 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

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS**

## **Section 5. Benefits** *continued*

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### **Extended care**

The Plan provides a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan physician and approved by the Plan. **You pay** nothing. All necessary services are covered, including:

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

### **Hospice care**

Supportive and palliative care for a terminally ill member is covered in the home. **You pay** nothing. Services include short-term inpatient care, limited to respite care and care for pain control and acute and chronic symptom management, outpatient care and family counseling; these services are provided under the direction of a Plan 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** \$50 per ambulance trip (a round trip counts as one).

### **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 17 for non-medical substance abuse benefits.

### **What is not covered**

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

### **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.

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS**

## **Section 5. Benefits** *continued*

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### **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 Kaiser Permanente medical offices and medical centers and from Kaiser Permanente providers. (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, transplants, and the services of specialized rehabilitation facilities, will not be available in other Kaiser Permanente service areas. If a benefit is limited to a specific number of days or visits, you are entitled to receive only that number of days or visits covered by the Plan in which you are enrolled.

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

At the time you register for services, you will be asked to pay the charge required by your enrollment in the local plan.

If you plan to travel to an area with another Kaiser Permanente plan and wish to obtain more information about the benefits available to you, please call the Customer Relations Department at 216/621-7100 or 800/686-7100.

### **Benefits Available While You Travel**

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

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

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

If you have any questions about how to use these benefits, call the Travel 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. Submit claims to Kaiser Foundation Health Plan of Ohio, Claims Department, P.O. Box 5316, Cleveland, Ohio 44101-9774. If the services are covered under this Travel Benefit, you will be reimbursed the reasonable charges for the care, up to a maximum of \$1200 per member 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.

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS**

## **Section 5. Benefits** *continued*

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### **Emergency Benefits**

#### **What is a medical emergency**

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

#### **Emergencies within the service area**

If you are in an emergency situation, call or go to the nearest Plan facility. The emergency telephone numbers are: Cleveland area (Parma Medical Center) - 216/445-4900; Akron area - 800/686-2240. These numbers are available 24 hours per day, 7 days a week.

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

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan physicians believe care can be better provided in a Plan-designated hospital, you will be transferred when medically feasible; **you pay** \$50 per ambulance trip. You can notify the Plan by calling one of the following numbers: In Cleveland call 216/445-4900 or toll free 800/686-2240 from anywhere in the United States.

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

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

**You pay...\$50** per hospital emergency room visit for emergency services that are covered benefits of this Plan. If you are hospitalized, the copayment is waived.

#### **Emergencies outside the service area**

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local telephone book under "Kaiser Permanente" You may also call the Customer Relations Department at the following phone number: 800/686-7100.

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-designated hospital, you will be transferred when medically feasible; **you pay** \$50 per ambulance trip.

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

**You pay...\$50** per hospital emergency room visit for emergency services that are covered benefits of this Plan.



## **Section 5. Benefits** *continued*

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### **What is covered**

- Emergency care at a physician's office or an urgent care center
- Ambulance service approved by the Plan; **you pay** a \$50 ambulance charge per trip
- Emergency care as an outpatient or inpatient at a hospital, including physicians' services

### **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 unless the Plan determines that the Member was outside the service area because of circumstances beyond her control

### **Filing claims for non-Plan providers**

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. Submit claims to Kaiser Foundation Health Plan of Ohio, Claims Department, P.O. Box 5316, Cleveland, Ohio 44101-9774. 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 9.

## **Mental Conditions/Substance Abuse Benefits**

### **Mental conditions**

#### **What is covered**

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

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

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS**

## **Section 5. Benefits** *continued*

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### **Outpatient care**

Up to 20 outpatient visits to Plan physicians, consultants or other psychiatric personnel each calendar year; two group therapy visits may be substituted for one individual therapy visit. **You pay** \$5 per covered individual visit and \$2.50 per covered group visit - all charges thereafter.

If you do not pay any of the charges required for services at the time you receive the services, you will be billed for those charges. You will also be required to pay an administrative charge of \$5 for each service for which a bill is sent.

### **Inpatient care**

Up to 30 days of hospitalization each calendar year reduced by one day for each two sessions of day or night care and reduced by one day for each session of home psychiatric care (up to a maximum of eight days). **You pay** nothing for first 30 days - all charges thereafter.

### **Day and night care**

If, in the professional judgment of a Plan physician, a member would benefit from day care or night care services, up to 60 sessions of such prescribed care are provided each calendar year. **You pay** nothing for 60 sessions - all charges thereafter. However, the number of sessions is reduced by two for each day of hospitalization for inpatient Mental Conditions services or by two for each session of home psychiatric care (up to a maximum of 16 day or night care sessions) received during the calendar year. Day and night care sessions, of no less than four and no more than 12 hour duration, are provided in a hospital-based or residential program. Such care includes all services of Plan physicians and mental health professionals. In addition, the following services and supplies as prescribed by a Plan physician are covered: room and board, psychiatric nursing care, group therapy, drugs and medical supplies.

### **What is not covered**

- Care for psychiatric conditions that in the professional judgment of Plan physicians are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan physician to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

### **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**

All necessary outpatient visits for follow-up care and dependency counseling. **You pay** \$5 per visit for individual therapy and nothing for group therapy.

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS**

## Section 5. Benefits *continued*

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### Inpatient care

Up to two treatments per calendar year in a specialized facility which provides a non-medical detoxification program. **You pay** nothing.

### What is not covered

- Treatment which is not authorized by a Plan physician
- Care in a specialized alcoholism, drug abuse or drug addiction treatment center (except as specifically noted above)
- Substance abuse treatment on court order or as a condition of parole or probation, unless determined by a Plan physician to be necessary and appropriate

### Prescription Drug Benefits

#### What is covered

Prescription drugs prescribed by a Plan physician and obtained at a Plan pharmacy will be dispensed for up to a 31-day supply. **You pay** \$5 per prescription unit or refill. It may be possible for you to receive refills by mail at no extra charge. Delivery may be made available at an additional charge. Ask for details at a Plan pharmacy.

Drugs are prescribed by Plan physicians and dispensed in accordance with the Plan's drug formulary. Non-formulary drugs will be covered when prescribed by a Plan physician. If the physician specifically prescribes a non-formulary drug because it is medically necessary, the non-formulary drug will be covered. If you request the non-formulary drug when your physician has prescribed a substitution, the non-formulary drug is not covered. However, you may purchase the non-formulary drug from a Plan pharmacy at prices charged to members for non-covered drugs.

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

- Drugs for which a prescription is required by law
- Oral contraceptive drugs and diaphragms
- Contraceptive devices, implanted time-release drugs and injectable contraceptives. For Norplant, **you pay** a one-time copayment of \$180 per prescription. For all other internally-implanted time-release drugs and injectable contraceptives, **you pay** a one-time copayment equal to \$5 per prescription times the expected number of months the device or drug will be effective, not to exceed \$200. There will be no refund of any portion of these copayments if the device or implanted time-release drug is removed before the end of its expected life. For injectable contraceptives, such as Depo-provera, you pay a one-time copayment equal to the \$5 per prescription copayment times the number of months the drug will be effective, not to exceed the cost of the drug.
- Insulin
- Glucose test strips
- Drugs for covered infertility treatments. **You pay** 50% of charges per prescription unit of refill.
- Certain antacids
- Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU)
- Disposable needles and syringes needed to inject covered prescribed medication
- Intravenous fluids and prescribed drugs for home use, some implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS**

## **Section 5. Benefits** *continued*

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### **Limited benefits**

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

If you do not pay any of the charges required for services at the time you receive the services, you will be billed for those charges. You will also be required to pay an administrative charge of \$5 for each service for which a bill is sent.

### **What is not covered**

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

## **Other Benefits**

### **Vision care**

#### **What is covered**

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, eye refractions for eyeglasses (to provide a written lens prescription) may be obtained from Plan providers. **You pay** \$10 per visit.

#### **What is not covered**

- Corrective eyeglasses and frames or contact lenses
- Examinations for contact lenses and the fitting of contact lenses
- Refractions for contact lenses
- Eye exercise

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS**

## Non-FEHB Benefits Available to Plan Members

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

### (VAPP) Value Added Purchasing Plans

Value Added Purchasing Plans (VAPPs) were developed to provide members with lower prices on health-related goods and services that may not be covered by their basic or supplemental health plans. The Value Added Purchasing Plans use Kaiser Permanente's ability to direct its members to vendors in exchange for reduction in prices for those goods and services. Members of Kaiser Permanente are eligible for substantial savings on the following goods and services:

#### Dental VAPP

Dental VAPP allows Members to purchase dental services at favorable prices from selected community dentists. Members must use one of the Affiliated General Dentists participating in Kaiser Permanente's Dental VAPP. For a listing of Affiliated General Dentists and a schedule of complete benefits, call 216/621-7100 or 800/686-7100.

#### Vision VAPP

Vision VAPP entitles Kaiser Permanente members to special discounts on designated optical goods and services purchased from quality vision care suppliers conveniently located throughout Northeast Ohio. Members must obtain their eyeglass examinations or refractions at Kaiser Permanente. Prescriptions must be filled at a participating optical provider for members to receive discounts of 15% - 20% on designated optical goods and services. For additional information, contact Kaiser Permanente at 216/621-7100 or 800/686-7100.

TO QUALIFY FOR DISCOUNTS AND SAVINGS ON DENTAL AND VISION VAPPS, MEMBERS MUST PRESENT THEIR KAISER PERMANENTE IDENTIFICATION CARD AT THE TIME OF SERVICE OR PURCHASE.

### Medicare Prepaid Plan Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 21, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the Plan, ask whether the Plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid

plan. Contact us at 216/621-7100 or 800/686-7100 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 216/621-7100 for information on the benefits available under the Medicare HMO.

### Expanded Dental Benefits

Kaiser Permanente is pleased to offer Federal employees, retirees and dependents a new choice of dental coverage to supplement what is currently available to you through the Federal Employee Health Benefits Program. The benefits of this program are designed to enhance the level of dental benefits (Dental VAPP) that you currently receive through Kaiser Permanente. Your Dental VAPP coverage through Kaiser Permanente is not affected by this enhanced product offering. This new supplemental coverage is through Delta Dental, a national dental provider, and is only available to members of Kaiser Permanente.

### DeltaPremier

DeltaPremier, a table of allowances program, allows you to choose any licensed dentist, however, discounted pricing is available only through Delta's provider network. After you satisfy a deductible, Delta will pay a predetermined amount toward each covered service. You will not need to satisfy a deductible toward covered preventive services you receive. DeltaPremier offers a full range of covered services: diagnostic, preventive, restorative, endodontics, periodontics, oral surgery, and both fixed and removable prosthodontics. Orthodontic coverage is not available. Covered services will be phased in over a three-year period.

	Monthly Premium
Self:	\$18.45
Self and One Party:	\$33.45
Family:	\$52.45

DeltaPremier is only available to you if you are enrolled in Kaiser Permanente's Plan for FEHB. If you enroll in DeltaPremier, your payments will be made directly to Delta. Payroll deduction is not available for this program. You do not need to purchase this program to receive Kaiser Permanente Dental VAPP coverage.

### How to Enroll

An enrollment form for DeltaPremier is included in your Kaiser Permanente enrollment kit. If you would like more information on DeltaPremier, please call Delta Dental at 800/932-0783; TDD 888/373-3582.

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

## Section 6. General exclusions – Things we don't cover

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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.

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## Section 7. Limitations – Rules that affect your benefits

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### Medicare

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

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

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

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

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

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 800/638-6833.

### 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.

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## **Section 7. Limitations – Rules that affect your benefits** *continued*

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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 provided or 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

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### **You have a right to information about your HMO.**

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

If you want specific information about us, call 216-621-7100, or write to Kaiser Foundation Health Plan of Ohio, North Point Tower, 1001 Lakeside Avenue, Cleveland, OH 44114. You may also contact us by our website at <http://www.kaiserpermanente.org>.

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

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

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

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

### **When are my benefits and premiums effective?**

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

### **What happens when I retire?**

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

### **What types of coverage are available 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 stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who is incapable of self-support.

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

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

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



## Section 8. FEHB FACTS *continued*

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### **Are my medical and claims records confidential?**

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

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

## **Information for new members**

### **Identification cards**

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

### **What if I paid a deductible under my old plan?**

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

### **Pre-existing conditions**

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

## **When you lose benefits**

### **What happens if my enrollment in this Plan ends?**

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

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

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

### **What is former spouse coverage?**

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

### **What is TCC?**

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

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

## Section 8. FEHB FACTS *continued*

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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.

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## **Inspector General Advisory: Stop Health Care Fraud!**

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### **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 216/621-7100 or 800/686-7100 and explain the situation.
- If we do not resolve the issue, call or write:

**THE HEALTH CARE FRAUD HOTLINE  
202/418-3300**

**U.S. Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street, NW, Room 6400  
Washington, D.C. 20415**

### **Penalties for Fraud**

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

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

Your agency may also take administrative action against you.

**Notes**

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**Notes**

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**Notes**

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## Summary of Benefits for Kaiser Foundation Health Plan of Ohio - 2000

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

	<b>Benefits</b>	<b>Plan pays/provides</b>	<b>Page</b>
<b>Inpatient care</b>	<b>Hospital</b>	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. <b>You pay</b> nothing. . . . .	12
	<b>Extended care</b>	All necessary services up to 100 days each calendar year. <b>You pay</b> nothing . . . . .	13
	<b>Mental conditions</b>	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. Two sessions of day or night care may be substituted for one day of inpatient care and vice versa. <b>You pay</b> nothing. . . . .	16
	<b>Substance abuse</b>	Two non-medical detoxifications per calendar year in a specialized treatment facility; <b>you pay</b> nothing. Also, covered under Mental conditions benefits . . . . .	17
<b>Outpatient care</b>		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. <b>You pay</b> \$10 per office and outpatient surgery visit; copays are waived for prenatal office visits; \$10 per house call by a physician for the first two visits per illness . . . .	10
	<b>Home health care</b>	All necessary visits by health care personnel. <b>You pay</b> nothing . . . . .	10
	<b>Mental conditions</b>	Up to 20 outpatient individual therapy visits per year (two group visits may be substituted). <b>You pay</b> \$5 per individual visit and a \$2.50 copay per group visit. . . . .	16
	<b>Substance abuse</b>	All necessary outpatient visits for counseling <b>you pay</b> \$5 per visit for individual therapy and nothing for group therapy. Also covered under Mental conditions benefits . . . . .	17
<b>Emergency care</b>		Reasonable charges for services and supplies required because of a medical emergency. <b>You pay</b> \$50 for each emergency room visit received from Plan providers and non-Plan-designated hospitals and any charges that are not covered by this Plan . . . .	15
<b>Prescription drugs</b>		Drugs prescribed by a Plan physician and obtained at a Plan pharmacy. <b>You pay</b> \$5 per prescription unit or refill . . . . .	18
<b>Dental care</b>		No current benefit	
<b>Vision care</b>		Refractions for eyeglasses only. <b>You pay</b> \$5 per visit . . . . .	19
<b>Out-of-pocket maximum</b>		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of \$4,052 per Self Only or \$12,156 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copayment maximum does not include the cost of prescription drugs, outpatient mental health services beyond the 20th visit; inpatient mental health copayments, if any, copayments for contraceptive devices, reconstructive surgery, durable medical equipment, prosthetic devices, orthotic appliances and CORF services. . . . .	5

## 2000 Rate Information for Kaiser Foundation Health Plan of Ohio

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

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

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

Type of Enrollment	Code	<u>Non-Postal Premium</u>				<u>Postal Premium A</u>		<u>Postal Premium B</u>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>		<u>Biweekly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	641	\$70.22	\$23.41	\$152.15	\$50.72	\$83.10	\$10.53	\$83.10	\$10.53
Self and Family	642	\$172.32	\$57.45	\$373.41	\$124.47	\$203.94	\$25.85	\$201.02	\$28.77