KAISER PERMANENTE
Kaiser Foundation Health Plan
of the Mid-Atlantic States, Inc.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

2000

A Health Maintenance Organization

Serving: Metropolitan Washington, DC, Area and Metropolitan Baltimore, Maryland Area

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

Enrollment code:
E31 Self only
E32 Self and family

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

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

Authorized for distribution by the:

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OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE

FEHB
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Introduction

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, MD 20849

This brochure describes the benefits you can receive from Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., under its contract (CS 1763) 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 Mid-Atlantic States, Inc. 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 preventative 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

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 7.7% for Self Only or 5.1% for Self and Family.

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

The copayment for chemotherapy, radiation therapy, and inhalation therapy visits will decrease from $5 to no charge per visit. (See page 11).

Coverage for durable medical equipment (DME) will increase. This Plan now covers various items of DME at specified copays. (See page 12).

Short-term outpatient rehabilitative therapy visits will increase from up to two consecutive months per condition to up to 40 visits or 90 days, whichever is greater, per condition. Speech and occupational therapy will increase to up to 90 days per condition. (See page 11).

Contraceptive drugs, devices, and implants will be covered at the standard prescription drug copay amount. (See page 17).

The copay for disposable needles and syringes needed for injecting covered prescribed drugs and self-administered chemotherapeutic drugs and oral chemotherapeutic agents will increase from $0 to $7. (See page 17).

Smoking cessation drugs will be covered with a 50% copay based on the average wholesale price. (See page 17).

Anti-obesity drugs will be covered with a 50% copay based on the average wholesale price. (See page 17).

Section 2. How we change for 2000, *continued*

The copay for ovulation stimulants will increase from 25% to 50% of the average wholesale price. (See page 17).

This Plan now provides coverage for drugs prescribed for acute conditions through its Mail Order program, at a $5 copay per prescription or refill. (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:

The District of Columbia;

Montgomery, Prince George's, Baltimore, Carroll, Hartford, Howard and Anne Arundel Counties in Maryland; the City of Baltimore; the following Maryland zip codes:

Charles County – 20601, 20602, 20603, 20604, 20612, 20616, 20617, 20637, 20640, 20646, 20658, 20675, 20695; Calvert County - 20639, 20689, 20714, 20732, 20736, 20754; Frederick County - 21702, 21705, 21709, 21710, 21714, 21716, 21717, 21718, 21754, 21755, 21758, 21762, 21769, 21770, 21774, 21777, 21790, 21793;

The cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park, in Virginia; Arlington, Fairfax, Loudoun, and Prince William Counties in Virginia.

Ordinarily, you must get 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 the benefits of this Plan at any other Kaiser Permanente facility. We also pay for follow-up services, or continuing care services while you are traveling outside the service area, as described on page 13-14; and for emergency care obtained from any provider, as described on page 13-14. 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 live out of the area, you should consider enrolling in another plan. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employment or retirement office.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services. If you do not pay at the time you receive your service, you will be billed for the service. We also will bill you an additional $10. This charge will be added to each service for which you did not pay.

After **you pay** $1,500 in copayments or coinsurance for one family member, or $3,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs, chiropractic and acupuncture services, dental and the $25 charge paid for follow-up or continuing care 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 Foundation Health Plan of the Mid-Atlantic States, Inc., is a Federally qualified Health Maintenance Organization. The Plan has been delivering prepaid health services to Washington, D.C., area residents since December 1972. Presently it serves nearly 550,000 members in the Washington, D.C., and Baltimore, Maryland metropolitan areas.

Section 3. How to get benefits, *continued*

This Plan offers comprehensive health care at Plan Medical Centers, community hospitals and other designated locations conveniently located throughout the Washington, D.C., and Baltimore, Maryland metropolitan areas. Health Plan contracts with the Mid-Atlantic Permanente Medical Group, P.C. ("Plan physicians"), an independent multi-specialty group of 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 physical therapy and laboratory and X-ray, are available at Plan facilities and other designated locations. Hospital care is provided at 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 gynecologist without having to obtain a referral. You may also receive mental conditions and substance abuse conditions services, eye examinations and refractions without a referral.

Choose your PCP from this Plan's provider directory. The directory, which is updated on a regular basis, lists the physicians' addresses and phone numbers, and lets you know whether the physician is accepting new patients. To get a directory, call the Member Services Department at 301/468-6000 or 800/777-7902. If you want to receive care from a specific physician who is listed in the directory, call the physician to verify that he or she still participates with the Plan and is accepting new patients.

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 Member Services Department at 301/468-6000 or 800/777-7902. 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 the services you will receive. You should return to your primary care physician after your consultation with the specialist. If your specialist recommends additional visits or services, your primary care physician will review the recommendation and authorize the visits or services, as appropriate. You should not go to a specialist unless your primary care physician and your Plan 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

Section 3. How to get benefits, *continued*

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.

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 until the end of your postpartum care.

What do I do if my specialist leaves the Plan?

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

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. 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) is the subject of a new drug or new device application on file with the FDA; or (3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or (4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or (5) is subject to the approval or review of an Institutional Review Board; or (6) requires an informed consent that describes the service as experimental or investigational; then this Plan considers that service supply or drug to be experimental, and not covered by the Plan. This Plan and its Medical Group carefully evaluate whether a particular therapy is safe and effective or offers a degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical literature.

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

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

1. Be in writing;
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

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

1. Maintain our denial in writing;
2. Pay the claim;

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

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 301/468-6000 or 800/777-7902 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 also give your claim expedited treatment. 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.

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, D.C. 20044.

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

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, 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. **You pay** a $10 per office visit charge for the following:

- Preventive care, including office visits for children over 3 years of age. Pediatric visits for children up to age 3 are provided at no charge.
- 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.
- Consultations by specialists.
- Diagnostic procedures, such as laboratory tests and X-rays at no charge.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and post-natal care by a Plan physician. Copays are waived for scheduled prenatal visits and the first post-partum visit. 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 hospital 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 covered 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 on non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast

Section 5. Medical and Surgical Benefits, *continued*

cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Transplant services are not available for ovarian carcinoma. 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, and inhalation therapy at no charge.
- Surgical treatment of morbid obesity.
- Prosthetic devices (breast protheses and surgical bras, as well as their replacement).
- Home health services of physicians, nurses and health aides, including intravenous fluids and medications, 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.
- Medical food and low protein modified food products for the treatment of inherited metabolic disease will be covered if the medical food and low protein modified food products are: (a) prescribed and pre-authorized as medically necessary for the therapeutic treatment of inherited metabolic diseases; and (b) administered under the direction of a physician; at no charge.
- Medically necessary foot care.
- All necessary medical or surgical care in a hospital or extended care facility from Plan physicians and other plan providers.

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

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 (except as shown on page 18 under Dental care) including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any dental care involved in treatment of temporolmandibular joint (TMJ or temporalmandibular) pain dysfunction syndrome.

Cleft lip and Cleft palate: Coverage shall include benefits for inpatient or outpatient expenses arising from orthodontics, oral surgery, and orthologic, audiological, and speech/language treatment for the management of the birth defect cleft lip or cleft palate or both.

General Anesthesia for Dental Care: General anesthesia and associated hospital or ambulatory services for dental care provided to children under the age of 7 or children with developmental disabilities when a successful result could not be expected from the use of local anesthesia. Coverage is also provided for children under age 17 who are extremely uncooperative, fearful, or uncommunicative and for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other morbidity. Coverage is also provided for adults age 17 and older when the member's medical condition necessitates that the dental services be performed in a hospital or ambulatory surgical center for the safety of the member (e.g., heart disease, hemophilia). Coverage is not provided for the professional dental component.

Qualified Medical Clinical Trials: Clinical trials that provide treatment for life threatening conditions; or for prevention, early detection, and treatment studies of cancer. Treatment or studies are being conducted in a Phase I, II, III, or IV clinical trial for cancer; or Phase II, III, or IV clinical trial for any other life threatening condition. Coverage may be provided for a Phase I clinical trial for these conditions on a case by case basis.

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 physical therapy is provided for up to 40 visits or 90 days, whichever is greater, if significant improvement can be expected within the 40 visits or 90

Section 5. Medical and Surgical Benefits, *continued*

days; **you pay** $10 per visit. Speech and occupational therapy is provided for up to 90 days if significant improvement can be expected within 90 days; **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. You may receive outpatient or inpatient therapy as part of a specialized therapy program in a specialized rehabilitation facility for up to two months per condition; **you pay** nothing.

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

Durable Medical Equipment (DME): Rental or purchase of Medicare-approved durable medical equipment for use in the member's home will be provided for up to three months at no charge following: (a) an authorized hospital confinement; (b) an authorized confinement in a sub-acute facility; (c) an authorized confinement in a specialized rehabilitation facility; and (d) an authorized outpatient surgical procedure. This Plan will determine whether the equipment will be rented or purchased. Bilirubin lights for home use and apnea monitors for infants up to age 3 will be provided for a period not to exceed 6 months; **you pay** nothing. Oxygen and oxygen equipment for home use is provided when the need for the oxygen and equipment meets Medicare guidelines and is prescribed by a Plan Provider; **you pay** nothing for the first three months, 50% of non-member rates for each additional authorized month. Liquid oxygen and oxygen tents are not covered. Equipment used for adult and pediatric asthmatics such as spacers, peak-flow meters, and nebulizers will be provided when purchased at a Plan Pharmacy; **you pay** $5 per spacer, $10 per peak-flow meter, and $30 per nebulizer.

Alternative therapy services: Chiropractic and acupuncture services will be provided as a component of the Plan's complementary and alternative medicine services, when your primary care physician, in consultation with the Plan's Complementary and Alternative Medicine Department, determines that such care is appropriate. The services will be covered only when medical improvement can be reasonably expected to occur. Chiropractic and acupuncture services are provided for up to 20 visits per therapy, per calendar year. **You pay** $15 per visit.

Blood Products, including gamma globulin and anti-hemophiliac factors

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 government licensing
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- External and internally implanted hearing aids
- Homemaker services
- Long-term rehabilitative therapy
- Transplants not listed as covered
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism
- Orthopedic and prosthetic devices, such as braces, foot orthotics, artificial limbs, and lenses following cataract removal
- Devices, equipment, supplies and prosthetics related to sexual dysfunction
- Cardiac rehabilitation
- Whole blood and packed red blood cells

Hospital/Extended Care Benefits

What is covered

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

Hospital care

- 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 products and the administration of blood, biologicals, supplies, and equipment ordinarily provided or arranged as part of inpatient services

Extended care

The Plan provides a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate. **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

Hospice care

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

Ambulance service

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

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan physician determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization and anesthesiology cost, 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 16 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, or care in an intermediate care facility
- Whole blood and packed red blood cells

Benefits Available Away From Home

Services From Other Kaiser Permanente Plans

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

When you are 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.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

Benefits Available Away From Home, *continued*

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

At the time you register for services, you will be asked to pay the copayment required under your enrollment in this plan.

If you plan to travel to an area with another Kaiser Foundation Health Plan and wish to obtain more information about the benefits available to you from that Kaiser Foundation Health Plan, please call the Member Services Office at 310/468-6000 in the Washington D.C. area or 800/777-7902 in the Baltimore, Maryland area.

Benefits Available While You Travel

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

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

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

If you have any questions about how to use these benefits, call the Travel Benefit Information Line at 800/390-3509. You may obtain the Travel Benefits for Federal Employees brochure by calling this number. You should pay the provider at the time you receive the service. Submit a claim to the Plan for the services on this Plan's Claim for Follow-up/Continuing Care Medical Form, with necessary supporting documentation. Submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Submit claims to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., P.O. Box 6233, Rockville, Maryland, 20849-6233. 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 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 requires immediate medical or surgical attention. 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, please call the Plan's 24-hour emergency number 800/677-1112. Emergency care is available through Kaiser Permanente 24 hours a day, 7 days a week.

In extreme emergencies, if you are unable to contact your physician, 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. It is your responsibility to ensure that the Plan has been notified.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan physicians believe care can be better provided in a Plan hospital, you will be transferred when medically feasible, with any ambulance charges covered in full.

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

Plan pays...

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

You pay...

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

Emergencies outside the service area

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local telephone book under "Kaiser Permanente". You may also obtain information about these facilities by calling 301/468-6000.

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, with any ambulance charges covered in full.

Plan pays...

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

You pay...

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

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 physicians' services
- Ambulance service approved by the Plan

What is not covered

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

Filing claims for non-plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. Submit claims to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., P.O. Box 6233, Rockville, Maryland, 20849-6233. 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.

Emergency Benefits, *continued*

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, methadone treatment, and maintenance
- Hospitalization (including inpatient professional services)

Outpatient care

Unlimited visits to Plan physicians, consultants, or other psychiatric personnel each calendar year; **you pay** nothing for the 1st through 5th visits; thereafter, you pay $10 for an individual visit and $5 for group visits 6 through 20; then, $30 for an individual visit and $5 for group visits for the remainder of the calendar year.

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

Inpatient care

Unlimited number of days each calendar year; **you pay** nothing.

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 and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

Outpatient visits to Plan providers for treatment; **you pay** nothing for each visit.

Inpatient care

Acute detoxification; the Plan provides unlimited number of days for rehabilitative services in a hospital or specialized facility; **you pay** nothing.

What is not covered

- Treatment that is not authorized by a Plan physician
- 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 or referral physician and obtained at a Plan pharmacy will be dispensed for up to a 90-day supply, based upon the prescribed dosage and standard manufacturer's package size. **You pay** $7 per prescription unit or refill for drugs purchased at a Plan pharmacy. You can obtain drugs prescribed for acute conditions at $5 per prescription or refill if obtained through the Plan's Mail Order program.

Dental prescriptions are limited to formulary products for pain relief and antibiotics only.

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 provided at the $7 charge (unless another charge is specifically identified):

- Drugs for which a prescription is required by law
- Oral contraceptive drugs, diaphragms, and intrauterine devices
- Implanted time released drugs
- Injectable contraceptive drugs
- Insulin
- Diabetic test strips
- Self-injectable drugs, other than ovulation stimulants (**you pay** $7 per prescribed therapeutic course of treatment)
- Ovulation stimulants (**you pay** 50% of the average wholesale price)
- Anti-obesity drugs (**you pay** 50% of the average wholesale price)
- Smoking cessation drugs, when enrolled in a formal smoking cessation program (**you pay** 50% of the average wholesale price)
- Disposable needles and syringes needed for injecting covered prescribed drugs
- Self-administered chemotherapeutic drugs and oral chemotherapeutic agents

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

The Plan provides the following at no charge

- Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU)
- Immunosuppressant drugs required after a covered transplant
- Intravenous fluids and medications for home use
- Chemotherapy drugs

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

Other Benefits

Dental care

The following dental services are covered when provided by participating Plan general dentists. **You pay** copayments when services are performed by a general dentist. Services of a specialist can only be received by referral from a Plan general dentist. Higher copayments may apply for services received from a specialist.

Preventative and diagnostic services:

Initial and periodic examinations, bitewing X-rays, cleaning of teeth (prophylaxis) every six months, topical fluoride treatments, and preventive care training: **You pay** a $30 copayment per member per visit.

Schedule of dental services and fees:

Area Code	Procedure Name	General Dentist	Specialist Dentist
00120	Periodic Oral Exam (Every 6 Months)	Fc30	Nb
00140	Ltd Oral Evaluation - Problem Focused	Fc30	Nb
00150	Comprehensive Oral Evaluation	Fc30	Nb
00210	Intraoral-Compl Ser Incl Bitewings	34	37
00220	Intraoral-Periapical-First Film	Fc30	9
00230	Intraoral-Periapical-Each Add Film	Fc30	9
00240	Intraoral-Occlusal Film	Fc30	9
00270	Bitewing-Single Film	Fc30	9
00272	Bitewings - Two Films	Fc30	9
00273	Bitewings - Three Films	Fc30	16
00274	Bitewings - Four Films	Fc30	25
00330	Panoramic Film	28	31
00460	Pulp Vitality Tests	Fc30	16
00470	Diagnostic Casts	Fc30	Nb
	Preventive		
01110	Prophylaxis Adults (Every 6 Months)	Fc30	Nb
01120	Prophylaxis-Child (Every 6 Months)	Fc30	Nb
01201	Top Flor Incl Prop Age 16(Every 6 Mos)	Fc30	Nb
01203	Top Flor Excl Prop Age 16(Every 6 Mos)	Fc30	Nb
01330	Oral Hygiene Instruction	Fc30	Nb
01351	Sealant - Per Tooth-To Age 16 (Note D)	17	Nb
01510	Space Maintainer - Fixed Unilateral	184	Nb
01515	Space Maintainer - Fixed Bilateral	184	Nb
01520	Space Maintainer - Remov Unilateral	226	Nb
01525	Space Maintainer - Remov Bilateral	141	Nb
01550	Recementation Of Space Maintainer	21	Nb
	Restorative		
02110	Amalgam-One Surface Primary	27	Nb
02120	Amalgam-Two Surfaces Primary	35	Nb
02130	Amalgam-Three Surfaces Primary	39	Nb
02131	Amalgam-4 Or More Surfaces, Primary	50	Nb
02140	Amalgam-One Surface Permanent	30	Nb
02150	Amalgam-Two Surfaces Permanent	41	Nb
02160	Amalgam-Three Surfaces Permanent	51	Nb
02161	Amalgam-Four Or More Surfaces Perm	60	Nb
02330	Resin-One Surface Anterior	37	Nb
02331	Resin-Two Surfaces Anterior	51	Nb
02332	Resin-Three Surfaces Anterior	52	Nb
02335	Res > 3 Sur Or Inv Incisal Angle Ant	66	Nb
02510	Inlay-Metallic-One Surface	307	Nb
02520	Inlay-Metallic-Two Surfaces	334	Nb
02530	Inlay-Metallic-Three Surfaces	371	Nb
02540	Onlay Metallic - 3 Or More Surfaces	408	Nb
02610	Inlay-Porcelain/Ceramic-One Surface	498	Nb
02620	Inlay-Porcelain/Ceramic-2 Surfaces	498	Nb
02630	Inlay-Porcelain/Ceramic-3 Surfaces	498	Nb
02640	Onlay-Porc/Ceramic-Per Tooth	498	Nb
02650	Inlay-Compos/Resin-1 Surf (Lab Proc)	498	Nb
02651	Inlay-Compos/Resin-2 Surf (Lab Proc)	498	Nb
02652	Inlay-Compos/Resin-3 Or More Surf (Lab)	498	Nb
02710	Crown-Resin-Laboratory	235	Nb
02740	Crown-Porcelain/Ceramic Substrate	526	Nb
02750	Crwn-Prc Fused To Hi Noble Mtl	531	Nb
02751	Crwn-Prc Fused To Pred Bas Mtl	472	Nb
02752	Crwn-Porc Fused To Noble Mtl	502	Nb
02790	Crown-Full Cast High Noble Metal	510	Nb
02791	Crown-Full Cast Predom Base Metal	442	Nb
02792	Crown-Full Cast Noble Metal	465	Nb
02810	Crown-3/4 Cast Metallic	521	Nb
02910	Recement Inlay	34	Nb
02920	Recement Crown	34	Nb
02930	Prefab Stainl Stl Crwn-Prim Tooth	101	Nb
02931	Prefab Stainl Stl Crwn-Perm Tooth	106	Nb
02932	Prefabricated Resin Crown	157	Nb
02940	Sedative Fillings	34	Nb
02950	Crown Buildup (Substructure) W/Pins	101	Nb
02951	Pin Reten-Per Tooth In Add To Rest	22	Nb
02952	Cast Post & Core In Add To Crown	146	Nb
02954	Prefab Post & Core In Add To Crown	129	Nb
02970	Temporary Crown (Fractured Tooth)	84	Nb
02980	Crown Repair	84	Nb
	Endodontics		
03110	Pulp Cap-Direct Excl Final Rest	22	Nb
03120	Pulp Cap-Indirect Excl Final Rest	22	Nb
03220	Therapeutic Pulpotomy Exc Fin Rest	62	67
03310	Rc Ther - Ant Exc Final Restoration	253	319
03320	Rc Ther-Bicuspid Exc Final Restorat	294	496
03330	Rc Ther-Molar Exc Final Restoration	313	614
03350	Apexification/Recalc Per Trmt Visit	118	164
03410	Apicoectomy/Periradicular Surg-Ant	148	381
03421	Apico/Perirad Surg-Bicus First Root	148	465
03425	Apico/Perirad Surg-Molar First Root	148	487
03426	Apico/Perirad Srg-Molar Ea Add Root	49	185
03430	Retrograde Filling-Per Root	104	196
03450	Root Amputation-Per Root	104	252
03920	Hemisect W Rt Rem-Wo Rt Canal Therapy	125	224

Other Benefits, *continued*

Area Code	Procedure Name	General Dentist	Specialist Dentist
Periodontics			
04210	Gingivectomy/Gingivoplasty-Per Quad	222	297
04211	Gingivectomy/Gingivoplasty-Per Tth	59	90
04220	Ging Curettage Surg/Quad-By Report	67	140
04240	Gingival Flap Incl Rt Plan-Per Quad	222	381
04249	Crn Lengthn-Hard/Soft Tissue By Rep	260	358
04250	Muco-Gingival Surgery-Per Qdrant	260	370
04260	Oss Surg Inc Flap Ent, Grfts & Clos	371	661
04261	Osseous Graft	185	330
04262	Osseous Graft, Multiple	185	330
04268	Guid Tis Rgen Inc Sur Re-Ent By Rep	358	358
04270	Pedicle Soft Tissue Graft Procedure	178	420
04271	Free Soft Tissue Gft & Donor Site	260	510
04320	Provisional Splinting - Intracoronal	106	130
04321	Provisional Splinting - Extracoronal	74	134
04341	Perio Scaling/Root Planing - Per Quad	71	140
04355	Fm Debridmt Before Comp Trmt (Note A)	67	140
04910	Perio Maint After Active Ther (Note B)	45	67
Prosthetics Removable			
05110	Complete Denture - Upper	525	Nb
05120	Complete Denture - Lower	525	Nb
05130	Immediate Denture - Upper	525	Nb
05140	Immediate Denture - Lower	525	Nb
05211	Upper Part Dent-Resin Base Incl Clsp	381	Nb
05212	Lower Part Dent-Resin Base Incl Clsp	470	Nb
05213	Up Part Dent-Met Base, Res Sdl Incl Clsp	567	Nb
05214	Lo Part Dent-Met Base, Res Sdl Incl Clsp	567	Nb
05281	Uni Part Dent-Met Base, Cast Clsp	269	Nb
05410	Adjust Dent-Comp Or Part, Upr Or Lwr	73	Nb
05510	Repair Broken Complete Denture Base	56	Nb
05520	Repl Miss/Brkn T-Compl Dent-Ea T	45	Nb
05610	Repair Acrylic Saddle Or Base	56	Nb
05620	Repair Cast Framework	62	Nb
05630	Repair Or Replace Broken Clasp	50	Nb
05640	Replace Broken Teeth-Per Tooth	50	Nb
05650	Add Tooth To Existing Part Denture	73	Nb
05660	Add Clasp To Existing Part Denture	101	Nb
05710	Rebase Dnt-Comp Or Par, Upr Or Lower	196	Nb
05730	Reline Dnt-Comp Or Part, Chair (Note C)	134	Nb
05750	Reline Dent-Comp Or Part, Lab (Note C)	148	Nb
05820	Interim Part Dentures - Upr Or Lower	207	Nb
05850	Tissue Conditioning - Maxillary	50	Nb
05851	Tissue Conditioning - Mandibular	56	Nb
Prosthetics Fixed			
06210	Pontic-Cast High Noble Metal	525	Nb
06211	Pontic-Cast Predom Base Metal	484	Nb
06212	Pontic-Cast Noble Metal	459	Nb
06240	Pont-Porc Fused To Hi Noble Mtl	493	Nb
06241	Pont-Porc Fused To Pred Bs Mtl	431	Nb
06242	Pont-Porc Fused To Noble Metal	465	Nb
06520	Inlay-Metallic-Two Surfaces	353	Nb
06530	Inlay-Metallic-3 Or More Surfaces	392	Nb
06540	Onlay Metallic - 3 Or More Surfaces	431	Nb
06545	Rtain-Cast Mtl For Acid Etch Brdg	224	Nb
06750	Crown-Porc Fused To Hi Noble Metal	504	Nb
06751	Crown-Porc Fused To Predom Base Mtl	420	Nb
06752	Crown-Porc Fused To Noble Metal	454	Nb
06780	Crown-3/4 Cast High Noble Metal	476	Nb
06790	Crown-Full Cast High Noble Metal	537	Nb
06791	Crown-Full Cast Predom Base Metal	478	Nb
06792	Crown-Full Cast Noble Metal	465	Nb
06930	Recement Bridge	39	Nb
Oral Surgery			
07110	Single Tooth	47	53
07120	Each Additional Tooth	41	47
07130	Root Removal-Exposed Roots	28	39
07210	Surgical Removal Of Erupted Tooth	59	106
07220	Rem Impacted Tooth-Soft Tissue	52	129
07230	Rem Impacted Tooth-Part Bony	67	162
07240	Rem Impacted Tooth-Compl Bony	111	190
07250	Surg Rem Resid T Roots-Cutting Proc	59	106
07260	Oroantral Fistula Closure	170	213
07270	Tooth Reimplantation	104	241
07280	Surg Expos Imp/Unerup T-Ortho	125	207
07281	Surg Expos Imp/Unerup T-Aid Erup	88	168
07285	Biopsy Of Oral Tissue-Hard ****	74	129
07286	Biopsy Of Oral Tissue - Soft ****	74	112
07291	Transseptal Fiberotomy	34	34
07310	Alveolopl In Conj W Extrac-Per Quad	59	118
07320	Alveolopl No Extract-Per Quad	74	134
07410	Rad Exc-Lesion To 1.25cm ****	88	168
07420	Rad Exc-Lesion Over 1.25cm ****	141	286
07430	Exc Benign Tumor-Lesion To 1.25cm ****	111	179
07431	Exc Ben Tunor-Lesion Over 1.25cm ****	140	281
07450	Rem Odont Cyst/Tum-Les To 1.25cm	105	170
07451	Rem Odont Cyst/Tum-Les > 1.25cm	140	281
07460	Rem Nonodont Cyst/Tum-Les To 1.25cm	111	179
07461	Rem Nonodont Cyst/Tum-Les 1.25cm	148	297
07470	Rem Exostosis-Maxilla Or Mandible	193	280
07480	Part Ostectomy Gutter Or Sauceriz	281	281
07510	I&D Abscess-Intraoral Soft Tissue	59	78
07520	I&D Abscess-Extraoral Soft Tissue	59	78
07530	Rem Frn Bdy/Skn/Subcut Areo Tissue	120	179
07550	Sequestrectomy For Osteomyelitis	162	162
07910	Suture Simple Wounds Up To 5cm	39	39
07911	Suture Of Complex Wounds Up To 5cm	78	78
07960	Frenectomy Frenec/Frenot-Sep Proc	91	196
07970	Exc Of Hyperplastic Tissue-Per Arch	56	148
07971	Excision Of Pericoronal Gingiva	67	95
Orthodontics:			
08070	Orthodontic Fully Banded 2 Yr Case - Transitional	Nb	2375
08080	Orthodontic Fully Banded 2 Yr Case - Adolescent	Nb	2375

Other Benefits, *continued*

Area Code	Procedure Name	General Dentist	Specialist Dentist
Additional Procedures			
09110	Palliative Treatment	28	Nb
09210	Local Anesthesia	0	Nb
09220	General Anesthesia-First 30 Minutes	74	185
09221	Gen'l Anesthesia-Each Add'l 15 Min	37	123
09230	Analgesia	17	22
09240	Iv Sedation	111	179
09310	Consult (No Add'l Procs Indicated)	45	49
09910	Appl Of Desensitizing Med	28	28
09940	Occlusal Guards By Report	162	269
09951	Occlusal Adjustment-Limited	37	57
09952	Occlusal Adjustment-Complete	148	244
09980	Sterilization Surcharge	5	5
09990	After Hours Surcharge	25	25
09999	Broken Appointmt Fee - Per Half Hour	15	15

Footnotes:
**** Lab Fees For Excisions And Biopsies Are To Be Paid By The Patient.
* Orthodontic Benefits Are For Ages 19 And Under; Adult Orthodontics Is Not Covered. Treatment Beyond 24 Months Is The Responsibility Of The Patient. Orthodontic Treatment Related To Tmj Dysfunction Is Not Covered.

NOTE: Procedures Not Shown Are Not Covered By The Dental Plan. Fees Quoted In The General Dentist Column Apply Only When Performed By Your Participating General Dentist. If Specialty Care Is Required, Your General Dentist Can Refer You To A Participating Specialist. Procedures Performed By A Participating Specialist, Where Available, Are Discounted Off Area Usual And Customary Rates. These Discounted Fees Are Listed In The Specialist Column. Procedures Performed Without A Referral Or By A Non-Participating Specialist Are Not Covered.

Fc30 - Patient Pays A Fixed Fee Of $30 Per Visit For Any Diagnostic & Preventive Visit In Which Exam, Cleaning Or X-Ray Procedures, Except When Codes 0210, Complete Series, And 0330 Panoramic Are Performed. The $5 Sterilization Fee Cannot Be Charged For Any Visit In Which The Fc30 Applies.

Nb = No Benefit; Not A Covered Procedure.

Note A: Procedure 4355 (Full Mouth Debridement) - Limited To Once Per 36 Months.

Note B:Procedure 04910 (Periodontal Maintenance After Active Therapy) - Limited To Twice Within 12 Months After Osseous Surgery.

Note C:Procedures 05730 & 05750 (Reline Dentures) - Limited To Once Per 36 Mos.

Note D: Coverage For Sealants (Ada Code 1351) Is Limited To The First And Second Permanent Molars. Additionally, Coverage Is Limited To Patients Under Age 16.

There will be a $25 surcharge for covered dental services provided after-hours and a $15 broken appointment fee applies to each one half hour of scheduled appointment time. For a complete listing of participating Plan dentists please call the Kaiser Permanente Dental Plan in the Washington area 301/986-5600, 1-800/638-8847 in the Baltimore area or call the Plan's Member Services Department.

Other Benefits, *continued*

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered up to a maximum benefit amount per accident of $2,000. A sound natural tooth is one that has not been weakened by existing dental pathology, such as decay or periodontal disease, one that has been previously restored by a crown, inlay, onlay, porcelain restoration or treatment by endodontics. The need for these services must result from an accidental injury from an external force (not chewing). The accident must be reported to a Plan provider within 72 hours of the event. Services must be provided within the 12-month period immediately following the injury and must start within 60 days of the accident. You must pay $10 per office visit. Coverage under this benefit is for the most cost-effective procedure that, in the opinion of the Plan dental provider, would produce a satisfactory result. No benefits will be available to replace teeth that have been knocked out, or that have been so severely damaged that, in the opinion of the Plan dental provider, restoration is impossible.

What is not covered

- Hospitalization for dental procedures, except as covered under Hospital/Extended Care Benefits-Limited benefits
- Replacement of dentures or bridge work due to loss or theft or accidental injury
- Dental procedures or services for cosmetic purposes
- Other dental services not shown as covered
- Laboratory fees for biopsies and excisions
- Fully banded orthodontics for members ages 20 and over

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, this Plan provides certain vision care benefits from Plan providers.

- Routine eye examinations, including lens prescription for eyeglasses. **You pay** $10 per examination.
- Eyeglasses including frames and lenses, and the initial fitting and purchase of contact lenses. **You pay** all charges less 25% off the usual and customary charges on all purchases of eyeglass lenses and frames and less 15% off the usual and customary charge on the cost of the initial fitting and purchase of contact lenses. Members may apply the above discounts to purchases of lenses and frames as often as they wish.

What is not covered

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

- Eye exercises
- Cost of eyewear not purchased at Plan facilities

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.

Medicare Prepaid Plan Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on Page 23, annuitants and former spouses with FEHB coverage and Medicare Parts A & B may elect to either drop their FEHB coverage and enroll in a Medicare prepaid plan or remain enrolled in the FEHB Program and simultaneously enroll in the Medicare Prepaid plan when one is available in their area. Those members who choose to disenroll from the FEHB Program may then later re-enroll in the FEHB Program.

Most Federal annuitants have Medicare Part A (hospital coverage). Those without Medicare Part A may join this Medicare prepaid plan after they have elected to purchase Medicare Part A in addition to continuing to pay their Part B premium. Before you drop your FEHB coverage and apply for coverage in the Medicare Prepaid plan, please contact us so we may help you determine your Medicare A & B eligibility.

If you are interested in dropping your FEHB enrollment please contact your retirement system for more information. For information on the Medicare Prepaid Plan please contact us at the numbers listed below based on your residence:

- The District of Columbia and the following cities and counties in Virginia: Alexandria, Arlington, Fairfax, Fairfax City, Falls Church, Loudoun, Manassas, Manassas Park, Prince William, please call 800/281-8797.
- The following cities and counties in the State of Maryland: Baltimore, Baltimore City, and the following zip codes within Anne Arundel county: 20794, 21060, 21076, 21077, 21090, 21108, 21122, 21144, 21146, 21226 and 21240 please call (800) 203-2808.
- The following counties in the State of Maryland, Montgomery, Prince George's, and the following zip codes within Charles county: 20601, 20602, 20603, 20604, 20612, 20616, 20617, 20637, 20640, 20643, 20646, 20658, 20675 and 20695, please call 800/229-5591.

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. This program is designed to enhance the level of dental benefits that you currently receive through Kaiser Permanente. Your basic discounted dental 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.

Delta Premier

Delta Premier, a table of allowances program, allows you to choose any licensed dentists, 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. Delta Premier 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

Delta Premier is only available to you if you are enrolled in Kaiser Permanente's Plan for FEHB. You do not need to purchase this program to receive the basic dental coverage included in the plan. Payments will be made directly to Delta. Payroll deduction is not available for this program.

How to Enroll

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

Benefits on this page are not part of the FEHB contract

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

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

We do not cover the following:

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

Section 7. Limitations — Rules that affect your benefits

Medicare

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

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

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

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

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

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

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.

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

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 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 301/468-6000, or write to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 E. Jefferson St., P.O. Box 6103, Rockville, MD 20849-6103. You may also contact us by fax at 301/816-7482 or visit our website at http://www.kaiserpermanente.org or by email at kaiseronline.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 employment 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.

Section 8. FEHB Facts, *continued*

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 employment 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 a 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 employment 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

Section 8. FEHB Facts, *continued*

your ex-spouse's employment 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 employment 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 employment 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 employment 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 employment 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 employment 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 employment 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 employment 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 employment or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

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

Section 8. FEHB Facts, *continued*

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

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

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

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 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 payroll agency may also take administrative action against you.

Notes

Notes

Summary of Benefits for Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. - 2000

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

Benefits		Plan pays/provides	Page
Inpatient care	**Hospital care**	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	13
	Extended care	All necessary services, for up to 100 days per calendar year. **You pay** nothing	13
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for unlimited number of days of inpatient care per calendar year. **You pay** nothing	16
	Substance abuse	Inpatient rehabilitation services. **You pay** nothing for unlimited number of days in a hospital or specialized facility per calendar year	16
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 visit; nothing per house call by a physician	10–12
	Home health care	All necessary visits by nurses and health aides. **You pay** nothing per visit	11
	Mental conditions	Unlimited visits per year. **You pay** nothing for the first five visits, then $10 for individual visits, and $5 for group visits 6-20; then $30 for individual visits; and $5 for group visits for the remainder of the year	16
	Substance abuse	Outpatient counseling and treatment; **you pay** nothing	16
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** $35 per emergency room visit, except for services that are not covered benefits of this Plan	15-16
Prescription drugs		Drugs prescribed by a Plan physician and obtained at a Plan pharmacy. **You pay** $7 per prescription unit or refill	17
Dental care		Accidental injury benefit; **you pay** $10 per visit. Preventive dental care, comprehensive range of restorative, orthodontic, and other services. **You pay** copays for these services	18-21
Vision care		Refractions including lens prescription: **You pay** $10 per examination. Eyeglasses including frames and lenses, and the initial fitting and purchase of contact lenses (See page 21)	21
Out-of-pocket maximum		Copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach $1500 per Self Only enrollment or $3000 per Self and Family enrollment	6

2000 Rate Information for
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

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

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

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

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	E31	$70.50	**$23.50**	$152.75	**$50.92**	$83.43	**$10.57**	$83.43	**$10.57**
Self and Family	E32	$174.30	**$58.10**	$377.65	**$125.88**	$206.26	**$26.14**	$201.02	**$31.38**