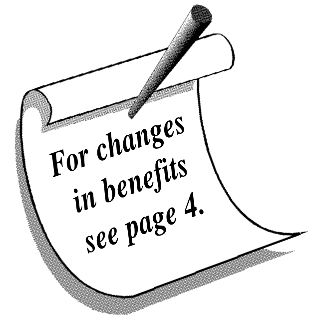
KAISER PERMANENTE®

Kaiser Permanente to be acquired by Capital District Physicians' Health Plan, Inc.

2000

A Health Maintenance Organization



Serving: Westchester County, New York

Enrollment in this Plan is limited; see page 5 for requirements.

Enrollment code:
QH1 Self Only
QH2 Self and Family

Westchester County, New York

The NCQA accreditation status for this service area is rated "Commendable." See the FEHB Guide for more information on NCQA.

Special notice: The Plan has eliminated a portion of its service area for **2000**. If you are enrolled in this Plan under enrollment code **K1** and live in one of the following areas, you must select another plan during the Open Season to continue to receive full benefits: **Southwestern New Hampshire and Massachusetts.**

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

Authorized for distribution by the:

United States Office of
Personnel Management
retirement and insurance service

RI73-086

Table of Contents

Introduction 2

Plain language 2

How to use this brochure 3

Section 1. Health Maintenance Organizations 4

Section 2. How we change for 2000 4

Section 3. How to get benefits 5

Section 4. What to do if we deny your claim or request for service 7

Section 5. Benefits 9

Section 6. General exclusions - Things we don't cover 17

Section 7. Limitations - Rules that affect your benefits 18

Section 8. FEHB FACTS 19

Inspector General Advisory: Stop Healthcare Fraud! 23

Summary of benefits . . . . Inside back cover

Premiums . . . . Back cover

Introduction

Kaiser Permanente
1 CHP Plaza
Latham, NY 12110

This brochure describes the benefits you can receive from Kaiser Permanente to be acquired by Capital District Physicians' Health Plan, Inc. (CDPHP) under its contract (CS 1896) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 4. Premiums are listed at the end of this brochure.

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 Permanente, to be acquired by CDPHP, 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 from a provider who does not contract with us, 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 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 167.6% for Self Only or 198.3% for Self and Family.

Hearing aids are no longer covered. (See page 11.)

The copayment for prescription drugs will change to $5 for generic prescriptions and $10 for brand name prescriptions (unless another charge is specifically identified). (See page 15.)

Kaiser Permanente, to be acquired by Capital District Physicians' Health Plan, Inc. (CDPHP). This change does not effect benefits or rates.

Services from other Kaiser Permanente Plans and benefits available while you travel for follow-up care and continuing care are no longer available because this Plan will no longer be affiliated with Kaiser Permanente.

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:

Westchester County, New York;

Ordinarily, you must receive your care from physicians, hospitals and other providers who contract with us. We also pay for emergency care obtained from any non-Plan provider, as described on page 13. 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 permanently outside of the area, you should consider enrolling in another plan. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

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.

Your out-of-pocket expenses for benefits under this Plan are limited to the stated copays required for a few benefits.

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. 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?

This Plan offers comprehensive health care through a group of medical providers and affiliated specialists (Plan physicians). These medical offices are where your physician and his or her support services are located. Plan physicians arrange any necessary specialty care. Other services, such as physical therapy and laboratory and X-ray, are available at Plan facilities and other designated locations. Hospital care is provided through the Plan at several community hospitals.

You must receive your health care services at Plan facilities, except if you have an emergency.

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.

Choose your primary care physician at the medical office or an affiliated practice most convenient for you. Use this Plan's provider directory in making your choice. The directory, which is updated on a regular basis, lists the physicians' addresses, phone numbers, and lets you know whether the physician is accepting new patients. To get a directory, call the Member Relations Department at 800/305-1992 in New York. 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.

Notify the Plan of the primary care physician you choose. Ask the Plan for a PCP selection form, then complete and return it to the Plan. If you need help choosing a primary care physician, call the Plan. You may change your primary care physician or your health center by notifying the Plan. The change is effective 30 days after we receive your notice.

Section 3. How to get benefits *continued*

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 in to 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 the Member Relations Department at 800/305-1992. 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 your specialist for a specified number of visits. You will not need to obtain additional referrals. Your primary care physician will obtain Plan authorization for these visits.

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

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

What do I do if my specialist leaves the Plan?

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

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

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

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

Section 3. How to get benefits *continued*

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

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

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

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

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information.

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

When may I ask OPM to review a denial?

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

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

Call us at 800/305-1992 and we will expedite our review.

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

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

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

Are there other time limits?

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

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

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.

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.

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

Your records and the Privacy Act

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

Section 5. Benefits

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan physicians and other Plan providers. This includes all necessary office and outpatient surgery visits. **You pay** $10 per visit, but no additional copay for laboratory test and X-rays. Office visits for pre-natal care and well-baby care are provided at no charge. Within the service area house calls will be provided if in the judgement of the Plan physician such care is necessary and appropriate; **you pay** nothing for a physician's house call, or for home visits by physicians, nurses, and health aides.

The following services are included:

- Preventive care and periodic check-ups.
- Mammograms are covered as follows: for women age 35 through 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. 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 test and X-rays.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a plan physician. Copays are waived for maternity care. 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.
- One annual self-referred gynecological examination to participating plan gynecologist. All other examinations must be arranged or provided by your primary care physician.
- Voluntary sterilization and family planning services.
- Diagnosis and treatment of diseases of the eye.
- Allergy testing and treatment (such as allergy serum), including antigen materials.
- Blood, blood products and the administration of blood.
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

- Cornea, heart, heart-lung, kidney, liver, lung (single and double) and simultaneous pancreas-kidney transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Additionally, autologous bone marrow transplants (autologous stem and peripheral stem cell support) and high dose chemotherapy for the following conditions: breast cancer, multiple myeloma, and epithelial ovarian cancer. 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.
- Chemotherapy, radiation therapy, and respiratory therapy.
- Surgical treatment of morbid obesity.
- For homebound members residing in the service area, home health services of physicians, nurses, and health aides, when prescribed and directed by your Plan physician, who will periodically review the program for continuing appropriateness and need.
- Hearing tests.
- All necessary medical or surgical care in a hospital or extended care facility from Plan physicians and other Plan providers, at no additional cost to you.
- Office visits and related diagnostic tests in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer or any recommendation of a course of treatment for cancer. The specialist rendering the second medical opinion must be a Kaiser Permanente affiliated specialist to whom the member received a referral from a Plan primary care physician, unless the member receives an approved referral to a non-participating specialist from a Plan primary care physician. Any further care rendered beyond, or as a result of, the second opinion must be arranged by Plan physicians.
- 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, including shortening of the mandible or maxillae for cosmetic purposes, treatment of radicular, residual and follicular cysts; correction of malocclusion, and any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition that has resulted in a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. 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.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Benefits *continued*

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months. **You pay** nothing for inpatient care and $10 per outpatient session. Rehabilitation is provided on an inpatient basis as part of a specialized multidisciplinary therapy program in a specialized facility for up to two months per condition, when in the judgment of the Plan physician, significant improvement can be expected within two months. **You pay** nothing. This benefit is reduced by any covered inpatient rehabilitation days in a skilled nursing facility. Speech therapy is limited to treatment to restore normal speech. Occupational therapy is limited to services that assist the member to achieve self-care and improved functioning in other activities of daily living.

Diagnosis and treatment of infertility is covered. **You pay** $10 per visit. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI); **You pay** $10 per office visit. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization, gamete and zygote intrafallopian transfers and embryo transfers are not covered. Infertility services are not available when either member of the family has been voluntarily surgically sterilized. Drugs related to non-covered infertility treatments are not covered.

Cardiac rehabilitation following a heart bypass surgery or a myocardial infarction. You pay $20.

Orthopedic devices, prosthetic devices and durable medical equipment (DME), when intended to be used repeatedly and in the home are covered. You pay nothing for Norton-Brown back brace, neck brace for fracture, lenses following cataract removal, and any brace for treatment of scoliosis. For all other orthopedic and prosthetic devices and DME, the Plan pays a maximum of $1500 per member per year for any combination of these items. (This limit will not apply to breast protheses and surgical bras and their replacements). Oxygen prescribed by a Plan physician is covered; **You pay** 20% of the charges (not to exceed $3500). Foot orthotics are not covered. The Plan will select the provider or vendor that will furnish covered devices and DME. DME coverage is limited to the standard item of DME in accord with the Plan's formulary guidelines, that adequately meets the medical needs of the member. The following items are not covered under DME: comfort and convenience equipment; exercise and hygiene equipment; disposable supplies; electronic monitors of the function of the heart or lungs (except apnea monitors for newborns), and devices to perform medical tests on blood or other bodily substances or excretions (except blood glucose monitors for diabetics); dental appliances; experimental or research equipment; devices not medical in nature such as sauna baths and elevators; modifications to the home or auto; and chiropractic appliances.

Chiropractic services (defined as manual manipulation of the spine to correct nerve interference caused by distortion, misalignment or subluxation of the vertebral column) is covered. All other forms of chiropractic services are excluded.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment, insurance or governmental licensing, or attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- External and internally implanted hearing aids
- Homemaker services
- Long-term rehabilitative and cognitive therapy
- Transplants not listed as covered
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism
- Special programs or clinics such as those for pain, sports, diet, weight reduction, acupuncture, biofeedback, hypnosis, or massage

Section 5. Benefits *continued*

Hospital/Extended Care Benefits

What is covered

Hospital care

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

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

Extended care

The Plan provides a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan physician. **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 care, limited to respite care and care for pain control and acute and chronic symptom management, outpatient care and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of six months or less. Durable medical equipment is covered as part of this benefit.

Ambulance service

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

Limited benefits

Inpatient dental procedures

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

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan physician determines that outpatient management is not medically appropriate. See page 15 for non-medical substance abuse benefits.

What is not covered

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Emergency Benefits

What is a medical emergency?

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

Emergencies within the service area

If you are in an emergency situation, call your primary care physician directly.

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 unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan 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.

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

Plan pays...

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

You pay...

$25 per visit to a hospital or urgent care center for emergency care services that are covered benefits of this Plan. If the emergency results in admission to a hospital, **you pay** nothing.

Emergencies outside the service area

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.

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

Plan pays...

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

You pay...

$25 per visit to a hospital or urgent care center for emergency care services that are covered benefits of this Plan.

What is covered

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

What is not covered

- Elective care or nonemergency care, except as specified in Benefits Available Away From Home
- Emergency or 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 Permanente, Claims Department, P.O. Box 15109, Albany, New York 12212-5109. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 7.

Mental Conditions/Substance Abuse Benefits

Mental Conditions
What is covered

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

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

Outpatient care

Up to 30 outpatient visits to Plan mental health providers each twelve-month period (a new twelve-month period begins after twelve months have elapsed since your first visit). **You pay** $5 per visit for each covered visit. Unless an appointment is canceled at least 24 hours in advance, the member must pay a charge of $25 for the broken appointment.

Inpatient care

Up to 60 days of hospitalization each calendar year. **You pay** nothing for the first 60 days and all charges thereafter.

Day and night care

If, in the professional judgment of a Plan physician, a member would benefit from day care or night care services, up to 120 sessions of such prescribed care are provided without charge each calendar year. However, the number of such sessions is reduced by two sessions for each day of hospitalization for inpatient Mental Conditions services received during the calendar year. Day and night care sessions, of no less than four and no more than 12 hour duration, are provided in a hospital-based or residential program. Such care includes all services of Plan physicians and mental health professionals. In addition, the following services and supplies as prescribed by a Plan physician are covered: room and board, psychiatric nursing care, group therapy, drugs and medical supplies.

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.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Benefits *continued*

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. In addition, the Plan provides:

Outpatient care

Up to 60 outpatient visits to Plan providers in each twelve-month period for treatment. **You pay** $5 per visit for each covered visit. Unless an appointment is canceled at least 24 hours in advance, the member must pay a charge of $25 for the broken appointment.

Inpatient care

Up to 30 days per calendar year for substance abuse rehabilitation (intermediate care) programs in a substance abuse detoxification or rehabilitation center approved by the Plan. **You pay** nothing during the benefit period, and all charges thereafter.

Day and night care

If, in the professional judgment of a Plan physician, a member would benefit from day care or night care services, up to 60 sessions of such prescribed care are provided without charge each calendar year. However, the number of such sessions is reduced by two sessions for each day of hospitalization for Substance Abuse services received during the calendar. Day care and night care sessions, of no less than six and no more than 12 hours duration, are provided. Such care includes all services of Plan physicians and mental health professionals. In addition, the following services and supplies as prescribed by a Plan physician are covered: room and board, psychiatric nursing care, group therapy, drugs and medical supplies.

What is not covered

- Treatment which 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 Plan physicians or dentists and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. If you choose a physician in one of our health centers as your primary care physician, prescriptions must be filled at a health center pharmacy. If you choose an affiliated physician group physician as your primary care physician, prescriptions can be filled at either an affiliated network pharmacy or a health center pharmacy. **You pay** $5 per generic or $10 per brand name prescription or refill. It may be possible for you to receive refills by mail at no extra charge. Delivery may be made available at an additional charge. Ask for details at a Plan pharmacy.

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

The following drugs are drugs provided at the $5 charge for each generic prescription or a $10 charge for each brand name prescription (unless another charge is specifically identified):

- Drugs for which a prescription is required by law
- Oral contraceptive drugs and contraceptive diaphragms

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

- Implanted time-release drugs and injectable contraceptives. For Norplant, **you pay** a one-time $200 per prescription charge. For Depo Provera, you pay $15. For all other internally-implanted time-release drugs and injectable contraceptives, **you pay** a one-time payment equal to $5 per prescription times the expected number of months the drug will be effective, not to exceed $200. There will be no refund of any portion of these payments if the drug is removed before the end of its expected life.
- Insulin
- Glucose test strips
- Smoking cessation drugs. Coverage is limited to one course of treatment per calendar year under the following conditions:
  1) the drug is prescribed by a Plan physician; and
  2) the member enrolls in a Plan-approved behavioral intervention program
- Injectable drugs for covered infertility treatments
- Medically necessary enteral formulas proven to be effective as a disease specific treatment for individuals who are or will become malnourished or suffer from disorders which, if untreated, will cause disability, retardation or death
- Modified solid food products for the treatment of certain inherited diseases of amino acid or organic acid metabolism up to a maximum of $2500 per person per 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.

The Plan provides the following drugs at no charge:

- Any equipment necessary to use a prescribed drug
- Disposable needles and syringes needed for injecting covered prescribed medication
- Intravenous fluids and medication for home use

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Benefits *continued*

Other Benefits

Dental care

What is covered

The following dental services are provided by participating Plan dentists: **You pay** nothing.

- Bite wings and full mouth x-rays (when necessary)
- Instructions in plaque control (twice per year)
- Basic prophylactic cleaning (twice per year)
- Topical application of sealant and fluoride (when necessary)
- Examination of teeth (twice per year)
- Space maintainers (when necessary)
- Scaling (when necessary)

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury. **You pay** nothing. All follow-up care must be obtained from Plan dentists.

What is not covered

- Other dental services not shown as covered
- Dental implants

Vision care

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.

What is covered

- Eye refractions, including lens prescriptions for eyeglasses. **You pay** a $10 copay per refraction
- Initial lenses following cataract surgery and lenses for keratoconus. **You pay** nothing.

What is not covered

- Corrective lenses (except as noted above) or frames (including the fitting of the lenses)
- Eye exercises

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

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;
- 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.

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.

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

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 800/638-0668, or write to Kaiser Permanente, 1 CHP Plaza, Latham, NY 12110. You may also contact us by fax at 518/785-2741. Or you can visit our website at http://kaiserpermanente.org.

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

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

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

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

When are my benefits and premiums effective?

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

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

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

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

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

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.

Section 8. FEHB FACTS *continued*

When you lose benefits

What happens if my enrollment in this Plan ends?

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

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

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

What is former spouse coverage?

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

What is TCC?

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

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

Key points about TCC:

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

Section 8. FEHB FACTS *continued*

How do I enroll in TCC?

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

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

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

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

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

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

How can I convert to individual coverage?

You may convert to an individual policy if:

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

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

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

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

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

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

Inspector General Advisory:
Stop Health Care Fraud!

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

• Call the provider and ask for an explanation. There may be an error.

• If the provider does not resolve the matter, call us at 800/305-1990 and explain the situation.

• If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

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

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

• Try to obtain services for a person who is not an eligible family member; or

• Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Notes

Summary of Benefits

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 AND FOLLOW UP AND CONTINUING CARE ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN PHYSICIANS.**

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital physician care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	**12**
	Extended care	All necessary services for up to 100 days per calendar year. **You pay** nothing	**12**
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 60 days of inpatient care per year. **You pay** nothing	**14**
	Substance abuse	Up to 30 days per year in a substance abuse treatment program. **You pay** nothing	**15**
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** $10 for office or outpatient surgery visit; copays are waived for maternity care and well-baby visits; nothing for a house call by a physician	**9**
	Home health care	All necessary visits by physicians, nurses and health aides. **You pay** nothing	**10**
	Mental conditions	Up to 30 outpatient visits per year. **You pay** $5 per visit	**14**
	Substance abuse	Up to 60 outpatient visits per year. **You pay** $5 per visit	**15**
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** $25 and any charges for services that are not covered benefits of this Plan.	**13**
Prescription drugs		Drugs prescribed by a Plan or referral physician and obtained at a Plan pharmacy. **You pay** $5 per generic or $10 per brand name prescription or refill	**15**
Dental care		Accidental injury benefit, preventive dental care. **You pay** nothing	**17**
Vision care		One refraction annually, including lens prescription. You pay $10 per refraction; initial lenses after cataract surgery. **You pay** nothing	**17**
Out-of-pocket maximum		Your out-of-pocket expenses for benefits under this Plan are limited to the stated copays required for a few benefits	**5**

2000 Rate Information for Kaiser Permanente

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	**QH1**	**$78.83**	**$56.33**	**$170.80**	**$122.05**	**$93.06**	**$42.10**	**$93.26**	**$41.90**
Self and Family	**QH2**	**$175.97**	**$153.26**	**$381.27**	**$332.06**	**$207.74**	**$121.49**	**$201.02**	**$128.21**