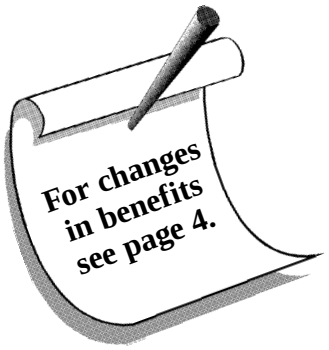
Kaiser Foundation Health Plan of Kansas City, Inc. 2000

A Health Maintenance Organization



Serving: Kansas City Metropolitan Area
Kansas and Missouri

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

Enrollment code:
HA1 Self Only
HA2 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 website at http://www.kaiserpermanente.org

Authorized for distribution by the:

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Table of Contents

Introduction

Kaiser Foundation Health Plan of Kansas City, Inc.
10561 Barkley
Overland Park, Kansas 66212

This brochure describes the benefits you can receive from Kaiser Foundation Health Plan of Kansas City, Inc. under its contract (CS 1948) 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 Foundation Health Plan of Kansas City, 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.

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 14.3% for Self Only or 14.3% for Self and Family.

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

The copay for outpatient surgery obtained in a hospital or outpatient surgery center will increase from $5 to $50. (See page 10).

Pulmonary rehabilitation will be covered with a $50 copay. (See page 11).

The short term rehabilitative therapy benefit no longer has a thirty visit limitation. (See page 11).

Chiropractic visits will now be covered with a $15 copay per visit up to a maximum of 20 visits per calendar year. (See page 11).

This Plan will pay 100% up to the first $1,000 for durable medical equipment, external prosthetic and orthopedic devices per calendar year. (See page 12).

The copay for prescription drugs will increase from $3 to $5. (See page 18).

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:

Kansas counties - Johnson, Leavenworth and Wyandotte;
Missouri counties -Cass, Clay, Jackson and Platte.

Ordinarily, you must receive your care from physicians, hospitals and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente service area, you can receive virtually all of the benefits of this Plan at any other Kaiser Permanente facility. We also pay for certain follow-up services, or continuing care services while you are traveling outside the service area, as described on page 14; and for emergency care obtained from any non-Plan provider, as described on page 16. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents permanently reside outside of the area, you should con sider 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 receiveyour service, you will be billed for ice. the service. We also will bill you an additional $5. This charge will be added to each service for which you did not pay.

After you pay $2,000 in copayments or coinsurance for one family member, or $4,500 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, cosmetic services, extended care services, durable medical equipment, external prostheses and braces, the $25 charges paid for follow up or continuing care, chiropractic services, dental care services and all mental conditions services except the first 20 outpatient visits do not count toward these limits and you must continue to pay for these services as described in this brochure.

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

Do I have to submit claims?

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

Section 3. How to get benefits, continued

Who provides my health care?

Kaiser Permanente offers comprehensive health care at six Plan facilities conveniently located throughout the Kansas City metropolitan area, and through referral specialists, hospitals and other providers in the community. The Plan contracts with the Permanente Medical Group of Mid-America, P.A., an independent multi-specialty group of physicians, and with Lee's Summit Family Care Center (Lee's Summit, Missouri) to provide or arrange all necessary physician care for Plan members. Medical care is provided through doctors and other skilled medical personnel working as medical teams. Specialists in most major specialties are available as part of the medical teams for consultation and treatment. These doctors are members of American Specialty Boards or are Board Eligible. Plan doctors also arrange for local referral specialists to provide any necessary specialty physician care not directly available from Plan doctors. Other necessary medical services, such as physical therapy and laboratory and X-ray services, are also available at Plan facilities. 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 health and optometry services without a referral.

Choose your primary care physician from this Plan's provider directory. The directory, which is updated on a regular basis, lists the physicians' addresses, phone numbers, and lets you know whether the physician is accepting new patients. To get a directory, call Member Services at 913/642-2662. If you want to receive care from a specific physician who is listed in the directory, call Member Services 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. If you need help choosing a primary care physician, call the Plan. You may change your primary care physician by notifying the Plan at any time. You are free to see other Plan physicians if your primary care physician is not available, and to receive care at other Kaiser Permanente facilities.

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

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

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

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

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

First, call the Member Services Department at 913/642-2662. 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.

Section 3. How to get benefits, continued

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 par ticipate 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.

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 evaluates whether a particular therapy is safe and effective or offers a degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical literature.

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

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

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

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

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

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

When may I ask OPM to review a denial?

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

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

Call us at 913/642-2662 and we will expedite our review.

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

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division 3 at 202/606-0755 between 8:00 a.m. and 5:00 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

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

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

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

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.

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 informationOPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

Medical and Surgical Benefits

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan physicians and other Plan providers. This includes all necessary office and outpatient surgery visits; **you pay** a $10 office visit copay and **you pay** $50 for each outpatient surgery in a hospital or outpatient surgery center. **You pay** $10 for each outpatient surgery in a medical office. There is no additional copay for laboratory and x-rays. **You pay** a $10 copay for all approved visits to a non-Plan provider's office. You pay nothing for well-child care visits, well woman care visits (routine pap smears and mammograms), prenatal and postnatal care, and personal health appraisals. 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.

- Preventive care, including well-baby care and periodic check-ups, no charge.
- Personal health appraisals.
- Mammograms - for women age 35 through 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years at no charge. In addition to routine screening, medically necessary mammograms to diagnose or treat your illness.
- Routine immunizations and boosters for children up to age 12, these are provided at no charge.
- Consultations with specialists.
- Diagnostic procedures, such as laboratory tests and X-rays (no charge).
- Complete obstetrical (maternity) care for covered females, including prenatal, delivery and post-natal care by a Plan physician at no charge. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services (including diaphragms).
- Diagnosis and treatment of diseases of the eye.
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum).
- The insertion of internal prosthetics 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, breastcancer; muliple myeloma; epithelial ovarian cancer; and testicular, mediastinal,retroperitoneal and ovarian germ cell tumors. Transplants are covered whenapproved by the Medical Group. Related medical and hospital expenses of thedonor are covered.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis (office visit charges will be waived if you enroll in Medicare Part B and assign your Medicare benefits to the Plan).
- Chemotherapy, radiation therapy, and respiratory therapy including colony stimulating drugs as required to maintain the member's general condition during treatment.
- Cardiac rehabilitation - following a heart transplant, bypass surgery or a myocardial infarction, is provided up to the level of rehabilitation where cardiac monitoring is no longer medically necessary.
- Surgical treatment of morbid obesity.
- Home health services of nurses, health aides, and wound care supplies, including intravenous fluids and medications, when prescribed by your Plan physician, who will periodically review the program for continuing appropriateness and need.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

Section 5. Benefits, continued

- Blood and blood products and the administration of blood (no charge).
- Visits to receive injections.
- Initial lenses following cataract removal (no charge)
- 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.
- Pulmonary rehabilitation. (**You pay** a $50 copay per pulmonary incident, in other words, if someone has a pulmonary incident and it requires them to make 10 trips for rehab they're only going to be responsible for paying $50 one time to cover the 10 visits.)

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

LIMITED BENEFITS

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, except as covered on page 19.

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 her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

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

Diagnosis and treatment of infertility is covered; **you pay** 50% of non-member rates. Artificial insemination is covered (including intracervical insemination (ICI), intrauterine insemination (IUI) and intravaginal insemination (IVI); **you pay** 50% of non-member rates per insemination procedure. 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 not covered. Drugs related to non-covered infertility treatments are not covered.

Chiropractic services – Up to 20 visits per calendar year of self-referred chiropractic services provided by Participating Chiropractors. Covered services include evaluation, laboratory services and X-rays, and treatment of musculoskeletal disorders. **You pay** $15 per visit. The following are not covered: non-neuroskeletal disorders; vocational rehabilitation services; thermography; transportation costs including ambulance; prescription drugs, vitamins, minerals, nutritional supplements or other, similar type products; MRI or other types of diagnostic radiology.

Section 5. Benefits, continued

Durable medical equipment and external prosthetic and orthopedic devices and braces are covered only when they are 1) able to withstand repeated use; 2) required to support or correct a defect of form or function or a permanently non-functioning or malfunctioning body part; 3) primarily used as an alternative to surgery or to speed recovery following surgery; and 4) in general use before April 1 of the prior year. Coverage includes orthopedic braces for scoliosis, breast prostheses and surgical bras, as well as their replacement, or equipment required as a part of acute primary care such as back braces, rib belts, slings and cervical collars. Purchase or rental is at the Plan's discretion. **You pay** nothing up to the first $1,000 of charge and **you pay** all charges over and above $1,000 per calendar year limit.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance or governmental licensing, 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 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.
- Devices, equipment, supplies and prosthetics related to the treatment of sexual dysfunction

Hospital/Extended Care Benefits

What is covered

Hospital care

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

- Semiprivate room accommodations; when a Plan physician determines it is medically necessary, the physician may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units
- 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 and approved by the Plan. **You pay** nothing. All necessary services are covered, including: bed, board and general nursing care

Prescribed drugs and their administration, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility

Hospice care

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

Section 5. Benefits, continued

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan physician. **You pay** $50**.**

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 18 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

Section 5. Benefits, continued

Benefits Available Away From Home

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

Services From Other Kaiser Permanente Plans

When you are visiting in the service area of another Kaiser Permanente plan, you are entitled to receive virtually all the benefits described in this brochure at any Kaiser Permanente medical office or medical center and from any Kaiser Permanente provider. **(If the Plan you are visiting has a charge that is different from the charges listed in this brochure, you will have to pay the charges imposed by the Plan you are visiting.)** If the Kaiser Permanente plan in the area you are visiting has a benefit that is different from the benefits of this Plan, you are not entitled to receive that benefit. Some services covered by this Plan, such as artificial reproductive services and the services of specialized rehabilitation facilities, will not be available in other Kaiser Permanente service areas. If a benefit is limited to a specific number of visits or days, you are entitled to receive only the number of visits or days covered by the Plan in which you are enrolled.

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

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

If you plan to travel to an area with another Kaiser Permanente plan and wish to obtain more information about the benefits available to you from that Kaiser Permanente plan, please call the Member Services Department at 913/642-2662 or outside the local calling area, call 800/726-5247.

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 most 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 on the Plan's Claim for Follow-up/Continuing Care Medical Services Form, with necessary supporting documentation. Submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card, as you would an emergency claim. Claims should be submitted to Kaiser Permanente, Member Claims, P.O. Box 378044, Denver Colorado, 80237. 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.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

Section 5. Benefits, continued

Emergency Benefits

What is a medical emergency

A medical emergency is an injury or the sudden and unexpected onset of a condition requiring 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 Medical Advice at 913/385-1155 or outside the local calling area, 800/870-5711. Medical Advice is open 24 hours a day, 7 days a week.

Urgent care is available at the Plan's Urgent Care Center located at the Overland Park Medical Office, 10100 W. 119th St., Overland Park, Kansas; and at Baptist Medical Office, 6675 Holmes Road, 4th and 5th Floors, Kansas City, Missouri.

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

If you need to be hospitalized, 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 facility would result in death, disability or significant jeopardy to your condition.

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

You pay...$50 per hospital emergency room visit at a Plan facility or $10 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency room visit results in admission to a hospital, the charge is waived.

Section 5. Benefits, continued

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".

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...$50 per hospital emergency room visit at a non-Plan facility 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 physician services
- Ambulance service approved by the Plan. You pay $50.

What is not covered

- Elective care or non-emergency care, except as specified in Benefits Available Away from Home
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. You should submit claim forms to Kaiser Permanente, Member Claims, P.O. Box 378044, Denver, Colorado, 80237. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 8.

Section 5. Benefits, continued

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 (**You pay** $20 for each hour of required diagnostic testing)
- Psychiatric treatment (including individual and group therapy)
- Medical management visits, including drug evaluation and maintenance. **You pay** $10 per visit**.** (These visits are not charged as mental health outpatient visits.)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 40 visits to Plan physicians, consultants, or other psychiatric personnel each calendar year; **you pay** nothing for the first visit; $10 per visit for individual therapy sessions at visits 2-20; and $25 per visit for individual therapy visits 21-40; you pay $10 for all group therapy visits. (In determining the number of visits, two group therapy visits count as one individual therapy visit; one individual therapy visit counts as two group therapy visits.)

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

Inpatient care

For the first 30 days of hospitalization each calendar year, **you pay** nothing**;** for days 31 through 45, **you pay** 50% of charges**.** For any additional days, you pay all charges. (The number of covered inpatient days will be reduced by one for every two days of day night care received.)

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. **You pay** 50% of charges for sessions 61-90. You pay all charges thereafter. However, the number of such sessions is reduced by two for each day of hospitalization for inpatient Mental Conditions services received during the calendar year. Day and night care sessions, of no less than four and no more than 12 hour duration, are provided in a hospital-based or residential program. Such care includes all services of Plan physicians and mental health professionals. In addition, the following services and supplies as prescribed by a Plan physician are covered: room and board, psychiatric nursing care, group therapy, drugs and medical supplies.

What is not covered

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

Section 5. Benefits, continued

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

- All necessary outpatient treatment visits. **You pay** nothing for the first visit; $20 per visit for all subsequent visits
- If you do not pay any of the charges required for services at the time you receive the services, you will be billed for those charges. You will also be required to pay an administrative charge of $5 or each service for which a bill is sent.

Inpatient care

- Up to 30 days of rehabilitative care from Plan providers, if it is determined by a Plan physician that you are unresponsive to outpatient treatment. **You pay** nothing**.** For any inpatient days in excess of thirty, you pay all charges.

What is not covered

- Treatment that is not authorized by a Plan physician
- Care in a specialized alcoholism, drug abuse or drug addiction treatment center
- 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 Benefit

Prescription drugs prescribed by Plan or referral physicians, or by general dentists or oral surgeons, and obtained at a Plan pharmacy, will be dispensed for up to a 30-day supply. **You pay** $5 per prescription or refill. Maintenance drugs can be filled in a 60-day supply; **you pay** $10. It may be possible for you to receive refills by mail at no extra 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 provided at the $5 charge (unless another charge is specifically identified):

- Drugs for which a prescription is required by law
- Contraceptive diaphragms
- Implanted time-release drugs. **You pay** a one-time payment equal to the $5 charge per prescription times the expected number of months the drug will be effective, not to exceed $200. The charge will be required, even when the drug is injected in the physician's office.
- Injectable contraceptives; **you pay** a one-time charge of $5 per injection times the expected number of months the drug will be effective, not to exceed $200. The charge for the drug applies when the contraceptive drug is injected during a medical office visit.
- Insulin, $5 per vial
- Glucose test strips

Section 5. Benefits, continued

The Plan provides the following at no charge

- Disposable needles and syringes needed for injecting covered prescribed drugs
- Any equipment necessary to use a prescribed drug
- 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
- Enteral elemental dietary formulas when used as primary therapy for regional enteritis
- Chemotherapy drugs
- Oral contraceptives

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
- Drugs related to infertility services
- Smoking cessation drugs, except for nicotine gum

OTHER BENEFITS

General Dentist

You Pay Restorative Services:

Amalgam (fillings silver, plastic, or composite)	$ 34 - $75
Inlay/onlay	$205 - 340
Crowns (Stainless Steel, cast or porcelain/metal)	$130 - 450
PERIODONTIC SERVICES:	
Root Planning (Per Quadrant)	$115
Occlusal Adjustment	$50 - 230
ENDODONTIC SERVICES:	
Root Canals	$240 – 420
ORAL SURGERY:	
Simple Extraction	$ 45
Extractions (Each Additional Tooth)	$ 40
Surgical Removal of Erupted Tooth	$ 85

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

Section 5. Benefits, continued

PROSTHETIC SERVICES:	
Dentures (Complete upper or lower)	$460 – 495
Partial Dentures	$405 – 505
Denture Relines	$135 – 170
ORTHODONTIC SERVICES:	
Standard Fully Banded Case	
(available to members age 19 and under)	$2,750

Oral exams, X-rays, prophylaxis (cleaning of teeth) every six months, fluoride treatment, and oral hygiene instruction are covered with a $5 copayment per member per visit.

This list of services and copayment ranges is a general summary and may vary depending on specific services required. These procedures are only available at participating general dental offices. Should your general dentist refer you to an affiliated specialist, the charges may be higher. If you have questions regarding specific covered services and corresponding copayments, please contact a Customer Service Representative at 800/445-9090.

VISION CARE

What is covered

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

What is not covered

- Eye exercises
- Corrective eyeglasses and frames or contact lenses (including the fitting of the lenses)
- Examination for prescription or contact lenses

Special Benefits for Medicare Eligible Enrollees

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

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

Like your FEHBP enrollment in this Plan, you are required to obtain your services from this Plan's physicians and providers, except for emergencies and out-of-area urgent care. The rules regarding enrollment in Kaiser Permanente Senior Advantage are fully explained in the Certificate of Coverage for Senior Advantage Federal members. For a copy of these rules, please contact Member Services at 913/642-2662 or 800/726-5247.

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

If you choose to enroll in Senior Advantage, you will be responsible for paying the Part B premium. You must make an affirmative enrollment in Senior Advantage. Refer to Certificate of Coverage for Senior Advantage Federal members for complete enrollment and disenrollment rules. You will also continue to pay the employee share of the FEHBP premium.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

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

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

We do not cover the following:

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

Section 7. Limitations – Rules that affect your benefits

Medicare

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

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

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

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

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

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 20.

Section 7. Limitations – Rules that affect your benefits, continued

Other group insurance coverage

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

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

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

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

Circumstances beyond our control

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

When others are responsible for injuries

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

TRICARE

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

Workers' compensation

We do not cover services that:

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

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

Medicaid

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

Other Government Agencies

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

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website 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 913/642-2662 or 913/632-3696 TDD, or write to Kaiser Foundation Health Plan of Kansas City, Inc., Member Services, 10561 Barkley, Ste. 200, Overland Park, Kansas 66212. You may also contact us by fax at 913/967-4630, or visit our website at www.kaiserpermanente.org.

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

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

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

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

When are my benefits and premiums effective?

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

What happens when I retire?

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

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

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

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

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

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

Section 8. FEHB FACTS, continued

Are my medical and claims records confidential?

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

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

Information for new members

Identification cards

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

What if I paid a deductible under my old plan?

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

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan ends?

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

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

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

What is former spouse coverage?

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

Section 8. FEHB FACTS, continued

What is TCC?

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

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

Key points about TCC:

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

How do I enroll in TCC?

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

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

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

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

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

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

Section 8. FEHB FACTS, continued

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 913/642-2662 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 for Kaiser Foundation Health Plan of Kansas City, 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.

	Benefit	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, up to 100 days per calendar year. **You pay** nothing	12
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 45 days of inpatient care reduced by one day for every two sessions of day or nightcare. **You pay** nothing for the first 30 days; 50% of charges for days 31 - 45; all charges thereafter.	17
	Substance abuse	Up to 30 days of rehabilitative care per year. **You pay** nothing	18
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** a $10 copay per office visit; $50 for each outpatient surgery in a hospital or outpatient surgery center; nothing per house call by a physician	10
	Home health care	All necessary visits by nurses and health aides. **You pay** nothing per visit	10
	Mental conditions	Up to 40 outpatient visits for individual therapy . **You pay** nothing for the first visit; $10 copay per visit for visits 2-20, and a $25 copay per visit for visits 21 - 40 and all charges thereafter.	17
	Substance abuse	All necessary outpatient visits. **You pay** nothing for the first visit and $20 for each subsequent visit.	18
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** $50 for services provided at Plan facilities. **You pay** $50 for services provided at non-Plan facilities, inside the service area and $50 for services provided outside the service area. **You pay** $10 per urgent care center visit	15
Prescription drugs		Drugs prescribed by a Plan physician and obtained at a Plan pharmacy. **You pay** a $5 copay per prescription unit or refill	18
Dental care		Accidental injury benefit. **You pay** 50% of the first $1,000 in charges per injury and all charges thereafter. Preventive dental care, comprehensive range of restorative, prosthetic, and other dental services. **You pay** copays for these services	19
Vision care		Refractions, including prescriptions for eyeglasses. **You pay** $10 per office visit	20
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $2,000 per Self Only or $4,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include prescription drugs or dental services. Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayment 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 catefory definitions in "The Guide to Federal Employees Health Benefits Plans for the 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 memeber 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	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	HA1	$60.10	$20.03	$130.22	$43.40	$71.12	$9.01
Self and Family	HA2	$155.06	$51.69	$335.97	$111.99	$183.49	$23.26