Kaiser Foundation Health Plan, Inc. Northern California Region

http://www.kaiserpermanente.org

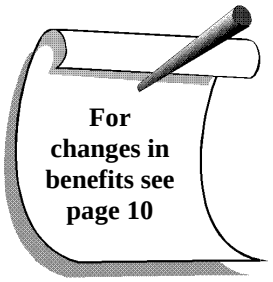
KAISER PERMANENTE®

2003

A Health Maintenance Organization

Serving: *Northern California service area*

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 8 for requirements.



This Plan has excellent accreditation from the NCQA.
See the 2003 Guide for more information on accreditation.

Enrollment codes for this Plan:

591 Self Only
592 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees
Health Benefits Program

RI 73-003

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 1-202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction

This brochure describes the benefits of Kaiser Foundation Health Plan, Inc. – Northern California Region, under our contract (CS1044-A) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The Northern California Region's administrative office is:

Kaiser Foundation Health Plan, Inc.
1950 Franklin Street
Oakland, CA 94612

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" or "Plan" means Kaiser Foundation Health Plan, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation, 1900 E Street NW, Washington, DC 20415.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider 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 our Member Service Call Center at 1-800-464-4000 and explain the situation.
    - If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

1-202-418-3300

OR WRITE TO:

The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of our most recent provider directory. HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments and coinsurance described in this brochure. When you receive emergency services or services covered under the travel benefit, from non-Plan providers, 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.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

We are a federally qualified health maintenance organization, and we have provided health care services to Californians for nearly 60 years. Kaiser Foundation Health Plan, Inc., is a California not-for-profit organization. This Plan is part of the Kaiser Permanente Medical Care Program, a group of not-for-profit organizations and contracting medical groups that serve over 8 million members nationwide. Our Medical Group, The Permanente Medical Group, Inc., operates Plan medical offices throughout Northern California.

If you want more information about us, call 1-800-464-4000, or write to 1950 Franklin Street, Oakland, California 94612. You may visit our website at www.kaiserpermanente.org, which lists the specific types of information that we must make available to you.

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 counties are:

Alameda; Contra Costa; Marin; Sacramento; San Francisco; San Joaquin; San Mateo; Solano; Stanislaus.

Portions of the following counties, as indicated by the zip codes below, are also within the service area:

Amador County:	95640, 95669
El Dorado County:	95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
Fresno County:	93242, 93602, 93606-07, 93609, 93611-13, 93616, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-22, 93724-29, 93740-41, 93744-45, 93747, 93750, 93755, 93759-62, 93764-65, 93771-80, 93782, 93784, 93786, 93790-94, 93844, 93888
Kings County:	93230-32
Madera County:	93601, 93604, 93614, 93637-39, 93643-45, 93653, 93669
Mariposa County:	93623
Napa County:	94503, 94508, 94515, 94558-59, 94562, 94567, 94573-74, 94576, 94581, 94599
Placer County:	95602-04, 95648, 95650, 95658, 95661, 95663, 95677-78, 95681, 95703, 95722, 95736, 95746-47, 95765
Santa Clara County:	94022-24, 94035, 94039-43, 94085-90, 94301-02, 94304-06, 94309-10, 95002, 95008-09, 95011, 95013-15, 95020**-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95101-03, 95106, 95108-42, 95148, 95150-61, 95164, 95170-73, 95190-94, 95196 **The Bells Station community, which lies within Gilroy Zip Code 95020, is not in the service area
Sonoma County:	94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-09, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492
Sutter County:	95659, 95668, 95674, 95676
Tulare County:	93618, 93666, 93673
Yolo County:	95605, 95607, 95612, 95616-18, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
Yuba County:	95692, 95903, 95961

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, including our mail order prescription program. You must pay the charges or copayments imposed by the Kaiser Permanente Plan you are visiting, with the exception of mail order prescriptions which are administered by your home Plan. See Section 5(g), Special Features, for more details. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described on page 43; and for emergency care obtained from any non-Plan provider, as described on page 33. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2003

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 29.9% for Self Only or 29.9% for Self and Family.
- This Plan is now two separate Regions in California, with different benefits and brochures. You must live or work in our Northern California service area to receive the benefits described in this brochure. (See Section 1).
- We have increased the copayment for office visits from $10 to $15.
- We increased the fee charged when you fail to make your copayment at the time you receive services from $10 to $13.50.
- We increased the copayment for allergy testing from $3 to $15.
- We moved coverage for ostomy and urological supplies to the orthopedic and prosthetic devices benefit and increased the copayment to 20% or our allowance.
- We increased the copayment for external sexual dysfunction devices covered under the durable medical equipment benefit from 20% of our allowance to 50% of our allowance.
- An aligned list of health education classes will be covered for all members, including smoking cessation.
- We extended the eligibility for hospice to members that have a terminal illness, with a life expectancy of 6 months or less to 12 months or less.
- We limit recovery services for chemical dependency in a non-medical residential facility to no more than 60 days of covered care per calendar year and no more than 120 days in any five-consecutive year period.
- We dispense less than a 100-day supply of prescription drugs that are in limited supply in the market.
- We increased the copayment for brand-name drugs from $20 to a $25 copayment.
- We cover smoking cessation drugs for as many courses of treatment per calendar year as medically necessary.
- We will charge the brand-name drug copayment for compounded products listed on our drug formulary, or that include ingredients requiring a prescription by law.
- We exclude drugs that shorten the duration of the common cold.
- We exclude drugs for the promotion, prevention, or other treatment of hair loss or hair growth.
- We exclude compounded products unless the product is listed on our drug formulary, or one of the ingredients requires a prescription by law.
- We exclude any requested packaging of drugs (such as dose packaging) other than the dispensing pharmacy's standard packaging.
- We will charge 50% of our allowance for excluded drugs that we have been covering and providing to you for FDA approved uses, if a Plan physician continues to prescribe the drug for the same reason.
- We changed some of your Kaiser Permanente Senior Advantage-FEHBP enhanced benefits. (See Section 9).

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at our Member Service Call Center at 1-800-464-4000.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, and you will not have to file claims.

• Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. Health Plan contracts with The Permanente Medical Group, Inc. and independent multispecialty groups of physicians to provide or arrange all necessary physician care for Plan members. Medical care is provided through physicians, nurse practitioners, and other skilled medical personnel working as medical teams at Kaiser Permanente facilities. We credential Plan providers according to national standards. Specialists in most major specialties are available as part of the medical teams for consultation and treatment. Other necessary medical care, such as physical therapy and laboratory and X-ray services, is also available. Plan physicians also arrange any necessary specialty care.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

• Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We offer comprehensive, affordable health care at 30 Plan facilities conveniently located throughout the San Francisco Bay, Sacramento, Stockton, and Fresno areas. These facilities include Medical Centers with full hospital facilities and Plan medical offices.

The Plan's facility directory lists the Plan's facilities and services, with the locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling our Member Service Call Center at 1-800-464-4000. You should use this directory to:

- Receive more information about facility locations and services
- Receive information about how to get established with a Plan physician

You must receive your health 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 at those Kaiser Permanente facilities. Under the circumstances specified in this brochure, you may receive follow-up or continuing care while you travel anywhere.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

• Primary care

Your primary care physician can be either a family practitioner, pediatrician, gynecologist, or internist. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. Please 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 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.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

• Specialty care

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a gynecologist, an optometrist, or our mental health and substance abuse Plan providers without a referral.

Here are other things you should know about specialty care:

- 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 certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she 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.

- If you are seeing a specialist and your 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.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  —terminate our contract with your specialist for other than cause; or

  —drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or

—reduce our service area and you enroll in another FEHB plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our Member Service Call Center immediately at 1-800-464-4000. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan 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 become a member of this Plan,

whichever happens first.

These provisions apply only to the hospital benefit of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. In certain cases your primary care physician can arrange for specialty services through a process we call a referral. Your physician must write a referral for services such as neurology, orthopedics, rheumatology, endocrinology, and any service that will not be provided by Plan physicians.

If a Plan physician determines that a referral for medical care is necessary, those arrangements will be prepared in writing and in advance of such medical care. If you receive care outside the Plan without a referral, you will be responsible for those expenses. We encourage you to participate in your medical care and discuss any questions about our referral process with your primary care physician. If your request for referral is denied, please contact our Member Service Call Center at 1-800-464-4000 or refer to Section 8 of this brochure.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments** — A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Example: When you see your primary care physician, you pay a copayment of $15 per office visit.
- **Deductible** — We do not have a deductible.
- **Coinsurance** — Coinsurance is the percentage of our allowance that you must pay for certain services you receive. Example: In our Plan, you pay 50% of our allowance for infertility services.
- **Fees when you fail to make your copayment** — If you do not pay your copayment at the time you receive services, we will bill you. You will be required to pay a $13.50 charge for each bill sent for unpaid services.

Your catastrophic protection out-of-pocket maximum for copayments and coinsurance

After your copayments and coinsurance total $1,500 per person or $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum. You must continue to pay copayments or coinsurance for these services:

- Prescription drugs
- Durable medical equipment
- Orthopedic and prosthetic devices
- Dental services
- Contraceptive devices
- Chiropractic services
- The $25 charge paid for follow-up or continuing care outside the service area

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

Section 5. Benefits – OVERVIEW

(See page 10 for how our benefits changed this year and page 66 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800-464-4000 *or* our website at www.kaiserpermanente.org.

Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary. • Plan physicians must provide or arrange your care. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • Note: Instead of a $15 charge, you pay only $5 if you enroll in our Medicare+Choice Plan and assign your Medicare benefits to the Plan.	IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians and other health care professionals • In a physician's office • In an urgent care center • Second opinion within Plan • Consultations with specialists	$15 per office visit
• During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	Nothing
At home	Nothing

Lab, X-ray, and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	
Routine screenings, such as: • Total blood cholesterol • Colorectal cancer screening, including —Fecal occult blood test —Sigmoidoscopy - every five years starting at age 50 • Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older • Routine pap test Note: You should consult with your physician to determine what is appropriate for you.	Nothing
Routine mammogram – covered for women age 35 and older, as follows: • Age 35 through 39, one during this five-year period • Age 40 through 64, one every calendar year • At age 65 and older, once every two consecutive calendar years Note: In addition to routine screening, we cover mammograms when medically necessary to diagnose or treat your illness.	Nothing
Routine immunizations, including but not limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under childhood immunizations) • Influenza/Pneumococcal vaccines • Hepatitis vaccinations	Nothing

(Preventive care, adult continues on next page)

Preventive care, adult *(continued)*	**You pay**
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance* • *Travel*	*All charges*
Preventive care, children	
• Well-child preventive care visits (23 months and younger) • Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations age 24 months and older, such as: —Eye exams to determine the need for vision correction —Ear exams to determine the need for hearing correction	$15 per office visit
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance*	*All charges*
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • First scheduled postnatal care visit Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c) for hospital benefits and Section 5(b) for surgery benefits.	Nothing
Not covered: • *Routine sonograms to determine fetal age, size, or sex*	*All charges*

Family planning	You pay
• Voluntary sterilization (See Surgical procedures Section 5(b)) • Genetic counseling • Insertion of surgically implanted time-release contraceptive drugs or injectable contraceptive drugs Note: The following devices or contraceptives are provided at no charge: intrauterine devices (IUDs); implanted time-release contraceptive drugs and injectable contraceptive drugs. We cover oral contraceptives, cervical caps, and diaphragms under the prescription drug benefit.	$15 per office visit
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: —Intravaginal insemination (IVI) —Intracervical insemination (ICI) —Intrauterine insemination (IUI) Note: We cover fertility drugs under the prescription drug benefit.	50% of our allowance
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Assisted reproductive technology (ART) procedures, such as:* *—In vitro fertilization* *—Embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm and donor eggs and services related to their procurement and storage*	*All charges*
Allergy care	
Allergy testing	$15 per office visit
Allergy treatment and injections	$3 per office visit
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: We limit high-dose chemotherapy in association with autologous bone marrow transplants to those transplants listed under Organ/Tissue Transplants on page 29. • Intravenous (IV)/Infusion therapy – Home IV and antibiotic therapy	Nothing for services provided by a non-physician provider $15 for services provided by a physician
• Respiratory and inhalation therapy • Growth hormone therapy (GHT) Note: We cover human growth hormone under the prescription drug benefit. • Dialysis – hemodialysis and peritoneal dialysis	$15 per office visit
Not covered: • *Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered*	*All charges*
Physical and occupational therapies	
We cover initial courses of therapy for up to two months per condition for: • Physical therapy by qualified physical therapists to restore bodily function when you have a total or partial loss of bodily function due to illness or injury • Occupational therapy by occupational therapists to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life Note: We provide subsequent courses of therapy for up to two months if you show significant improvement in your condition. Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction. • Multidisciplinary outpatient rehabilitation is provided for up to two months per condition. This includes diagnostic and restorative services comprising a program of physical, speech, occupational, and respiratory therapy, as well as certain other items and services that are medically necessary for rehabilitation. The two-month limit applies to all inpatient and outpatient multidisciplinary rehabilitative services you may receive for the same condition.	$15 per outpatient visit Nothing for inpatient
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*

Speech therapy	You pay
We cover initial and subsequent courses of therapy for up to two months per condition for: • Speech therapy by speech therapists when medically necessary	$15 per outpatient visit Nothing for inpatient
Hearing services (testing, treatment, and supplies)	
Hearing testing	$15 per office visit
Not covered: • *Hearing aids* • *Hearing tests to determine the most appropriate hearing aid*	*All charges*
Vision services (testing, treatment, and supplies)	
• Diagnosis and treatment of diseases of the eye • Eye refractions to determine the need for vision correction and provide a prescription for eyeglasses	$15 per office visit
Therapeutic contact lenses for the condition of aniridia for up to two lenses per eye in a 12-month period	Nothing
Not covered: • *Eyeglasses or contact lenses (except for the condition of aniridia)* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	$15 per office visit
Not covered: • *Cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained, or flat feet, or bunions or spurs; and of any instability, imbalance, or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Orthopedic and prosthetic devices	You pay
We cover internally implanted FDA-approved devices, including but not limited to: • Artificial joints • Pacemakers • Cochlear implants • Intraocular implants following cataract removal • Surgically implanted breast implants following a mastectomy Note: See Section 5(b) for coverage of the surgery to insert the device.	Nothing
We cover FDA-approved devices that are in general use and are required because of a defect in form or function of a permanently inoperative or malfunctioning body part, including but not limited to: • Artificial limbs and eyes and stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan podiatrist, physiatrist, or orthopedist • Enteral formula for members who require tube feeding per Medicare guidelines • Ostomy and urological supplies in accord with the Plan's formulary guidelines	20% of our allowance
Not covered: • *Comfort, convenience, or luxury equipment or features* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Shoes or arch supports, even if custom-made, except to treat diabetes-related complications when prescribed by a Plan podiatrist, physiatrist, or orthopedist*	*All charges*
Durable medical equipment (DME)	
• During a covered stay in a Plan hospital or skilled nursing facility We limit coverage to the standard item that meets your medical needs consistent with our Plan DME formulary guidelines.	Nothing

(Durable medical equipment (DME) continues on next page)

Durable medical equipment (DME) *(continued)*	**You pay**
For use in the home when intended to be used repeatedly. Includes but is not limited to: • Oxygen and oxygen dispensing equipment • Hospital beds • Wheelchairs including motorized when medically necessary • Crutches • Walkers • Blood glucose testing monitors and related supplies • Insulin pumps • Infant apnea monitors • Repairs and replacements resulting from normal use We limit coverage to the standard item that meets your medical needs consistent with our Plan DME formulary guidelines. We decide whether to rent or purchase the item, and choose the vendor. Note: We only provide DME in the Plan's service area.	20% of our allowance
• External devices used for the treatment of sexual dysfunction We limit coverage to the standard item that meets your medical needs consistent with our Plan DME formulary guidelines. We decide whether to rent or purchase the item, and choose the vendor. Note: We only provide DME in the Plan's service area.	50% of our allowance
Not covered: • *Comfort, convenience, or luxury equipment or features* • *Devices not medical in nature, such as sauna baths, exercise and hygiene equipment* • *Electronic monitors of the function of the heart or lungs, except for infant apnea monitors* • *Devices to perform medical tests on blood or other bodily substances or excretions, except diabetic testing equipment and supplies* • *Dental appliances* • *Experimental or research equipment* • *Modifications to the home or auto* • *Items which are no longer medically necessary must be paid for or returned*	*All charges*

Home health services	You pay
• Home health care ordered by a Plan physician and provided by a registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), or home health aide • Services include oxygen therapy, intravenous therapy, and medications Note: We only provide these services in the Plan's service area.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Services outside of our service area*	*All charges*
Chiropractic and alternative treatments	
Chiropractic services covering the diagnosis or treatment of neuromusculoskeletal disorders limited to 20 visits per year. You can access services in the following ways: Chiropractic services are provided through American Specialty Health Plans (ASH Plans). You will have direct access to a participating ASH Plans chiropractor without the need to obtain a Plan physician referral. You can obtain a list of ASH Plans Participating Providers by calling 1-800-678-9133. Specific details of this chiropractic benefit are listed in the ASH Plans' evidence of coverage/disclosure form. You phone the ASH Plans chiropractor you have selected for an initial examination. After the initial examination and except for chiropractic emergency services, your ASH Plans chiropractor is responsible to obtain authorization from ASH Plans for any additional chiropractic services on your behalf. ASH Plans will not cover any chiropractic services if you were referred through your Plan physician. NOTE: When necessary and prescribed by an ASH Plan chiropractor, you may receive up to $50 of chiropractic appliances per calendar year.	$15 per office visit

(Chiropractic and alternative treatments continue on next page)

Chiropractic and alternative treatments *(continued)*	**You pay**
Not covered: • *Naturopathic services* • *Hypnotherapy*	*All charges*
Educational classes and programs	
We cover a wide range of health education programs to help protect and improve your health. Examples of covered health education topics include: smoking cessation, pregnancy, depression and living with chronic conditions. • Selected health education programs and materials including information on how to use our services • Individual health education visits • Other health education programs, materials and services Note: Call the Member Service Call Center at 1-800-464-4000 for information on classes near you.	Nothing Nothing Nominal charges

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary. • Plan physicians must provide or arrange your care. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.). • YOUR PHYSICIAN MUST GET A REFERRAL FOR SOME SURGICAL PROCEDURES. Please refer to the referral information shown in Section 3 to be sure which services require a referral and identify which surgeries require a referral.	IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Treatment of burns • Normal pre- and postoperative care by the surgeon • Pre-surgical testing • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Insertion of internally implanted time-release contraceptive drugs and intrauterine devices (IUDs) • Insertion of other implantable time-release drugs • Injection of contraceptive drugs	$15 per office visit when provided on an outpatient basis Nothing when provided on an inpatient basis

(Surgical procedures continues on next page)

Surgical procedures *(continued)*	**You pay**
Note: The following devices or contraceptives are provided at no charge: intrauterine devices (IUDs), implanted time-release contraceptive drugs and injectable contraceptive drugs. We cover oral contraceptives, cervical caps, and diaphragms under the prescription drug benefit. • Treatment for sexual dysfunction or inadequacy • Insertion of internal prosthetic devices. See Section 5(a–Orthopedic and prosthetic devices for device coverage information.	$15 per office visit when provided on an outpatient basis Nothing when provided on an inpatient basis
Not covered: • *Reversal of voluntary surgical sterilization* • *Routine treatment of conditions of the foot*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: —the condition produced a major effect on the member's appearance; and —the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes • All stages of breast reconstruction surgery following a mastectomy, such as: —surgery to produce a symmetrical appearance on the other breast; —treatment of any physical complications, such as lymphedemas; and —breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$15 per office visit when provided on an outpatient basis Nothing when provided on an inpatient basis
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures or dislocations of the jaw or facial bones • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Medical and surgical treatment of TMJ • Other surgical procedures that do not involve the teeth or their supporting structures	$15 per office visit when provided on an outpatient basis Nothing when provided on an inpatient basis
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/Lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Limited benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover your transplant.	$15 per office visit when provided on an outpatient basis Nothing when provided on an inpatient basis
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of non-human artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided during a surgical procedure • Hospital (inpatient) • Ambulatory surgery center (outpatient)	Nothing

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary. • Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).	IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets NOTE: Your physician may prescribe accommodation or private duty nursing care if it is medically necessary. If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing

(Inpatient hospital continues on next page)

Inpatient hospital *(continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Plan physicians' and surgeons' services and supplies, including consultation and treatment by specialists • Take-home items Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The conditions for which we will provide hospitalization include hemophilia and heart disease. The need for anesthesia, by itself, is not such a condition.	Nothing
Not covered: • *Custodial care and care in an intermediate care facility* • *Personal comfort items, such as barber services, guest meals, and beds* • *Private nursing care unless medically necessary* • *Inpatient dental procedures*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Dressings, casts, and sterile trays • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	Nothing

Extended care benefits/skilled nursing care facility benefits	You pay
Up to 100 days per benefit period when you need full-time skilled nursing care. Your benefit period begins when you enter a hospital or skilled nursing facility and ends when you have not been a patient in either a hospital or skilled nursing facility for 60 consecutive days. 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	Nothing
Not covered: • *Custodial care* • *Care in an intermediate care facility*	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member: • You must reside in the service area • Services are provided in the home • Services are provided in a Plan-approved hospice facility Services include inpatient care, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately twelve months or less. Note: Hospice is a program for caring for the terminally ill that emphasizes supportive services, such as home care and pain control, rather than curative care of the terminal illness. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, physician services, and short-term inpatient care for pain control and acute and chronic symptom management. We also provide counseling and bereavement services for the individual and family members, and therapy for purposes of symptom control to enable the person to continue life with as little disruption as possible. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.	Nothing
Ambulance	
Professional ambulance service, including air ambulance, when medically appropriate	Nothing
Not covered: • *Transports that we determine are not medically necessary*	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

You are covered for medical emergencies anywhere in the world. In a medical emergency, call 911 or go to the nearest hospital. If you call 911, when the operator answers, stay on the phone and answer all questions.

Emergencies within our service area:

If you think you have a medical emergency, call 911 or go to the nearest hospital. To better coordinate your emergency care, we recommend that you go to a Plan Hospital if it is reasonable to do so considering your condition or symptoms. Please refer to the *Guidebook* for the location of Plan Hospitals that provide emergency care. If an ambulance comes, you (or your representative) should tell the paramedics that you are a Kaiser Permanente member.

Post-stabilization care is the services and supplies you receive after your treating physician determines that you are clinically stable following a medical emergency. We cover post-stabilization care if a Plan Provider provides it or if you obtain authorization from us to receive the care from a non–Plan Provider.

When you are sick or injured, you may have an urgent care need. An urgent care need is one that requires prompt medical attention, but is not a medical emergency. If you think you may need urgent care, call the appropriate appointment or advice nurse number at a Plan Facility. Please refer to the *Guidebook* for advice nurse and Plan Facility telephone numbers.

Emergencies outside our service area:

If you think you have a medical emergency, call 911 or go to the nearest hospital. If an ambulance comes, you (or your representative) should tell the paramedics that you are a Kaiser Permanente member.

Post-stabilization care is the services and supplies you receive after your treating physician determines that you are clinically stable following a medical emergency. We cover post-stabilization care if a Plan Provider provides it or if you obtain authorization from us to receive the care from a non–Plan Provider.

When you are sick or injured, you may have an urgent care need. An urgent care need is one that requires prompt medical attention, but is not a medical emergency. If you think you may need urgent care, call the appropriate

appointment or advice nurse number at a Plan Facility. Please refer to the *Guidebook* for advice nurse and Plan Facility telephone numbers. If you are temporarily outside the Service Area and have an urgent care need due to an unforeseen illness or injury, we cover the medically necessary services and supplies you receive from a non–Plan Provider if we find that the services and supplies were necessary to prevent serious deterioration of your health and they could not be delayed until you returned to the Service Area.

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local telephone book under Kaiser Permanente. These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling 1-800-227-2415.

How to Obtain Authorization

You must call us at 1-800-225-8883 (the telephone number is also on your ID card) to:

- Request authorization for post-stabilization care *before* you obtain the care from a non–Plan Provider if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible)
- Notify us that you have been admitted to a non–Plan Hospital. You must notify us within 24 hours of any admission or as soon as reasonably possible. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you don't notify us, as soon as reasonably possible, we will not cover any services and supplies you receive after transfer would have been possible

We know that extraordinary circumstances can delay your ability to call us, for example if you are unconscious or a young child without a parent or guardian. In these cases, you must call us as soon as it is reasonably possible. Please keep in mind that anyone can call us. If you don’t call us when it becomes possible for you to call, you will be financially responsible for the cost of the unauthorized services and supplies received after you became clinically stable.

Benefit Description	You pay
Emergency within our service area	
• Emergency room visit for emergency services Note: We waive the $50 if you are admitted to the hospital.	$50 per visit
Not covered: • *Elective care or non-emergency care (unless you receive prior authorization)* • *Urgent care at a non-Plan urgent care center*	*All charges*
Emergency outside our service area	
Emergency care as an outpatient or inpatient at a hospital, including physicians' services • Emergency room visit for emergency services • Emergency care at an urgent care center • Emergency care in a Kaiser Foundation hospital in another Kaiser Foundation Health Plan service area Note: See the "Travel Benefit" for coverage of continuing or follow-up care.	$50 per visit The amount you would be charged if you were a member in that service area
Not covered: • *Elective care or non-emergency care at non-Plan facilities (unless you receive prior authorization)*	*All charges*
Ambulance	
Professional ambulance service, including air ambulance, when medically appropriate	$50 per trip
Not covered: • *Transports we determine are not medically necessary*	*All charges*

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are clinically appropriate to treat your condition.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
We cover all diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: We cover the services only when we determine that the care is clinically appropriate to treat your condition, and only when you receive the care as part of a treatment plan developed by a Plan provider. Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment in favor of another.	Your cost sharing responsibilities are no greater than for other illnesses or conditions

(Mental health and substance abuse benefits continue on next page)

Mental health and substance abuse benefits *(continued)*	**You pay**
Diagnosis and treatment of psychiatric conditions, mental illness, and mental disorders. Services include: • Diagnostic evaluation • Treatment (including individual, family, and group therapy visits) • Crisis intervention and stabilization for acute episodes • Psychological testing that is medically necessary to determine the appropriate psychiatric treatment • Medication management and evaluation Diagnosis and treatment of alcoholism and drug abuse. Services include: • Treatment and counseling (including individual, family, and group therapy visits) • Outpatient detoxification (medical management of withdrawal from the substance) Note: You may see a Plan mental health or substance abuse provider for outpatient treatment without a referral from your primary care physician. Note: Your Plan provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you.	$15 per office visit
• Inpatient psychiatric care • Hospital alternative services, such as partial hospitalization and intensive outpatient psychiatric treatment programs • Inpatient substance abuse care and rehabilitation • Inpatient detoxification • Methadone treatment for a pregnant woman throughout the pregnancy and for two months after delivery Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan physician.	Nothing
Recovery services for alcoholism and drug abuse in a non-medical residential care facility Note: All inpatient and alternative services treatment programs require approval by a Plan physician. We cover up to 60 days per calendar year and no more than 120 days in any five consecutive year period of non-medical residential recovery care.	$100 per stay

(Mental health and substance abuse benefits continue on next page)

Mental health and substance abuse benefits *(continued)*	**You pay**
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Services we have not approved* • *Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* • *Services that are custodial in nature* • *Services rendered or billed by a school or a member of its staff* • *Services provided under a federal, state, or local government program* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms*	*All charges*

Limitation We may limit your benefits if you do not obtain a treatment plan.

Section 5 (f). Prescription drug benefits

	IMPORTANT	**Here are some important things to keep in mind about these benefits:** • We cover prescribed drugs and medications, as described in the chart beginning on the next page. • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	IMPORTANT	

There are important features you should be aware of. These include:

- **Who can write your prescription**. A Plan physician or any dentist must write the prescription. Drugs prescribed by dentists are not covered if a Plan physician determines that they are not medically necessary.
- **Where you can obtain them**. You must fill the prescription at a Plan pharmacy or another pharmacy that we designate, or through our mail order program.
- **We use a formulary**. A formulary is a listing of preferred pharmaceutical substances and formulas. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. The Plan uses this formulary to determine which prescribed drugs will be provided to members.

  Our formulary includes a list of prescription drugs that have been approved by our Pharmacy and Therapeutics Committee. This committee, which is comprised of Plan physicians and other Plan providers, selects prescription drugs for the formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets quarterly to consider adding and removing prescription drugs on the formulary. If you would like information about whether a particular drug is included on our formulary, please call the Member Service Call Center at 1-800-464-4000.

  If the physician specifically prescribes a non-formulary drug because it is medically necessary, the non-formulary drug will be covered. If you request the non-formulary drug when your physician has prescribed a substitution, the non-formulary drug is not covered. However, you may purchase the non-formulary drug from a Plan pharmacy at prices charged to members for non-covered drugs.
- **These are the dispensing limitations.** We provide up to a 100-day supply for most drugs, except certain drugs that have a significant potential for waste will be provided for up to a 30-day supply in any 30-day period. In addition, we may limit the provision of drugs that are in limited supply in the market. Please contact our Member Service Call Center at 1-800-464-4000 for the current list of these drugs. Maintenance medications may be obtained for up to a 100-day supply when ordered through our mail-order program.
- **When you have to file a claim.** When you receive drugs from a Plan pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Certain self-administered IV drugs and fluids requiring specific types of parenteral infusion, and the supplies required for their administration • Amino acid-modified products used to treat congenital errors of amino acid metabolism • Diabetes urine-testing supplies • Vaccines and immunizations approved for use by the Food and Drug Administration • Elemental dietary enteral formula when used as a primary therapy for regional enteritis	Nothing
• Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary. • Insulin • Certain insulin administration devices • Disposable needles and syringes for the administration of covered medications • Smoking cessation drugs are covered only if you participate in a Plan approved behavioral intervention program Note: The brand-name drug copayment will apply to compounded products listed on our drug formulary, or that include ingredients requiring a prescription by law.	\$10 per prescription for generic drugs \$25 per prescription for brand-name drugs All charges if you request a brand-name drug in place of a generic drug
• Oral contraceptives	\$10 per prescription for generic drugs and \$25 per prescription for brand-name drugs (up to a 3-cycle supply); all charges if you request a brand-name drug in place of a generic drug
• Cervical caps and diaphragms	\$25 per device

(Covered medications and supplies continue on next page)

Covered medications and supplies *(continued)*	**You pay**
• Fertility drugs • Sexual dysfunction drugs — Episodic drugs will be provided up to a maximum of 27 doses in any 100-day period. Additional prescribed doses during the same 100 days will be dispensed at our allowance. — Maintenance drugs that require doses at regulated intervals	50% of our allowance
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins and nutritional supplements that can be purchased without a prescription* • *Nonprescription drugs, unless they are included in our drug formulary* • *Medical supplies, such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Drugs that shorten the duration of the common cold* • *Drugs for the promotion, prevention, or other treatment of hair loss or growth* • *Compounded products unless the product is listed on our drug formulary, or one of the ingredients requires a prescription by law* • *Any requested packaging of drugs (such as dose packaging) other than the dispensing pharmacy's standard packaging* *Note: If a drug for which a prescription is required by law is excluded and we had been covering and providing it to you for a use approved by the FDA, we will continue to provide the drug upon payment of 50% of our allowance if a Plan physician continues to prescribe the drug for the same condition.*	*All charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
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 (including our mail order prescription program) at any Kaiser Permanente medical office or medical center. You must pay the charges or copayments imposed by the Kaiser Permanente Plan you are visiting, with the exception of mail order prescriptions which are administered by your home Plan. You will have to pay the charges imposed by the Plan you are visiting. If the Plan 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 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 the Kaiser Permanente Plan, please call our Member Service Call Center at 1-800-464-4000.

Travel benefit	Kaiser Permanente's travel benefits for Federal employees provide you with outpatient follow-up or continuing medical care when you are temporarily outside your home service area by more than 100 miles or outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency and urgent care benefits and include: • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast. • Outpatient continuing care for conditions diagnosed and treated within the previous 90 days by a Kaiser Permanente health care provider or affiliated Plan provider. Services include dialysis and prescription drug monitoring. • You pay $25 for each follow-up or continuing care office visit. This amount will be deducted from the payment we make to you. • Your benefit is limited to $1,200 each calendar year**.** • For more information about this benefit call 1-800-464-4000. • File claims as shown on page 48. *The following are not included in your travel benefits coverage:* • *Non-emergency hospitalization* • *Infertility treatments* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* • *Transplants* • *DME* • *Prescription drugs* • *Home health services*
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may talk with a registered nurse who will discuss treatment options and answer your health questions. You can obtain an advice nurse phone number for the nearest Kaiser Permanente facility in the white pages of your phone book under "Kaiser Permanente".
Services for deaf and hearing impaired	We provide a TTY/text telephone number 1-800-777-1370. Sign language services are also available.

Centers of excellence	Kaiser Permanente's National Transplant Network (NTN) was created to offer members greater choice of and access into Centers of Excellence (COE) that exceed minimum quality standards for experience (based on volume of cases and transplant team composition), outcomes, and service (waiting time and access to the Center). The goal is to ensure that members are treated at Centers where optimal outcomes can be expected, measured, and managed. Currently, the NTN contains 20 Centers that include 70 transplant programs. Transplant services provided through the NTN are heart, lung, heart/lung, liver, simultaneous kidney/pancreas, pancreas, small bowel, and bone marrow/stem cell (autologous and allogeneic).

Section 5 (h). Dental benefits

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • We cover hospitalization for dental procedures at a Plan hospital we designate only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure except as described below. • Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	IMPORTANT

Dental benefits

We have no dental benefits.

Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Eyewear discount

As a Kaiser Permanente FEHBP Member, you and your eligible dependents will be able to purchase eyewear at significant savings. When you visit any of the Northern California Health Plan Optical Departments, you will receive 25 percent off our allowance for frames and lenses and options such as no-line bifocals and prescription and non-prescription sunglasses. You will also be able to receive 25 percent off our allowance for cosmetic contact lenses and the required lens fitting.

Limitations & exclusions: This discount will apply only to purchased eyewear under the FEHBP basic coverage. The vision discount may not be coordinated with any other Kaiser Permanente Health Plan vision benefit. This discount will also not apply to any sale, promotional, or packaged eyewear program or for any contact lens Extended Purchase Agreement (which includes products purchased in this Agreement) or to low-vision aids or devices.

Expanded dental benefits

Kaiser Permanente is pleased to offer Federal employees, retirees, and dependents a choice of dental coverages to supplement your medical plan.

Option I/Delta Care
DeltaCare offers dental health maintenance organization (HMO) benefits that are administered by PMI, an affiliate of Delta Dental Plan of California. You select a dentist from the network of contracting DeltaCare dental offices that is most convenient for you and your family. With DeltaCare, there are no claim forms to worry about. DeltaCare also provides a full range of services that includes preventive, restorative, endodontics, periodontics, prosthetics, oral surgery, and orthodontics. Under this program, the subscriber pays a specific copayment for most covered services.

Option II/KPIC's Dental Plan
KPIC's Dental Plan, a table of allowances program, allows you to select any licensed dentist. After you satisfy a deductible, KPIC's Dental Plan will pay a predetermined amount that is specified in a table toward each covered service, and you pay the remainder of the fee. You do not need to satisfy a deductible toward covered preventive services you receive. KPIC's Dental Plan offers a full range of services; diagnostic, preventive, restorative, endodontics, periodontics, oral surgery, and both fixed and removable prosthodontics. Orthodontics is not available under the KPIC's Dental Plan.

Monthly Premium*	Option I/DeltaCare		Option II/KPIC's Dental Plan
	Monthly Premium	Quarterly Premium	Monthly Premium
Self Only	$ 9.55	$ 28.64	$ 24.37
Self & One Party	$ 15.97	$ 47.92	$ 43.35
Self & Two or More	$ 24.22	$ 72.66	$ 65.16

KPIC's Dental Plan and DeltaCare are available only if you enroll or are currently enrolled in the Kaiser Permanente Plan for FEHB Members. You do not need to enroll in either dental plan if you choose not to. All subscribers who enroll in either dental program, when eligible, must continue enrollment in the selected dental program until the next open enrollment period. This does not apply if employment is terminated.

How to enroll
Please use the enclosed postage-paid card to send in your application. If you would like more information on KPIC's Dental Plan, please call 1-800-933-9312. A Delta Dental representative will be able to assist you Monday through Friday, 6 a.m. to 6 p.m.

Payments for the KPIC's Dental Plan or DeltaCare programs will be made by automatic withdrawal from your checking, savings, or credit union account.

* These rates are effective January 1, 2003 through December 31, 2003.

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, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Section 5(d)), services under the Travel Benefit (see Section 5(g)), and services received from other Kaiser Permanente plans (see Section 5(g));
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs, or devices;
- Services, drugs, or 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;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or fill your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers or when you use the travel benefit. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital, and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call our Member Service Call Center at 1-800-464-4000.

When you must file a claim – such as for services you receive outside of the Plan's service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- Follow up services rendered out-of-area
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

If you have a malpractice claim

If you have a malpractice claim because of services you did receive, or did not receive, from a Plan provider, you must submit the claim to binding arbitration. The Plan has the information that describes the arbitration process. Contact our Member Services Call Center at 1-800-464-4000 for copies of our requirements. These will explain how you can begin the binding arbitration process.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for a referral:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within six months from the date of our decision; and (b) Send your request to us at: Kaiser Permanente, Member Relations, P.O. Box 12983, Oakland, CA 94604-2983; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial – go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

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

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's 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, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, 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 decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life-threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior referral, then call us at 1-888-987-7247 and we will expedite our review; or

(b) We denied your initial request for care or a referral, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Benefits Contracts Division 3 at 1-202-606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. If we are the secondary payer, and you received your services from Plan providers, we may bill the primary carrier.

- **What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.

- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The

Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. We will not waive any of our copayments.

Claims process when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-800-443-0815.

(Primary payer chart begins on next page.)

The following chart illustrates whether **the Original Medicare Plan** or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you – or your covered spouse – are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB		✓
(Ask your employing office which of these applies to you.)		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation)	
B. When you – or a covered family member – have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and	✓	
a) Are an annuitant, or		
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan, known as Medicare+Choice or Kaiser Permanente Senior Advantage, and also remain enrolled in our FEHB Plan. There is no additional premium to enroll in Senior Advantage. In this case, we have lowered or waived some of our copayments and coinsurance for your FEHB and Medicare coverage. If you would like information about our Medicare+Choice plan, please call 1-800-443-0815. Your Kaiser Permanente Senior Advantage-FEHBP benefits that we lowered or waived are:

- **Prescriptions**: $20 for each brand name drug for up to a 100-day supply. The same price applies to mail-order drugs.
- **Physician office visits**: $5 for physician/specialist office visits
- **Preventive services**: $5
- **Routine physical and hearing exams**: $5 for routine physical and hearing exam
- **Urgently needed care**: $5 for each visit to a Plan facility; $50 for each visit to a non-Plan facility in or out of the Plan's service area; Worldwide coverage
- **Vision services**:
  - — $5 for routine eye exam
  - — A flat allowance of $150 every 24 months will be applied to lenses, frames and contact lenses. A separate allowance of $150 per eye per lifetime will apply to post cataract eyewear covered by Medicare.
- **Dental services**:
  - — $0 for oral exams or X-rays
  - — $15 for cleanings, up to two office visits each year
  - — No referral necessary for network providers

You will also enjoy:

- Health/Wellness Education: No copayments for covered health education classes
- No deductibles and virtually no paperwork
- On-line access to health information and resources at our award-winning members only website
- Quarterly member communication in our "Senior Outlook" magazine

You must use Kaiser Permanente Plan and affiliated providers and continue to pay Medicare premiums.

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary if you use our Plan providers, but we will not waive or lower any of our copayments or coinsurance. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, 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 unless you involuntarily lose coverage or move out of the Medicare managed care service area.

- **If you enroll in Medicare Part B**

If you enroll in Medicare Part B, we require you to assign your Medicare Part B benefits to the Plan for its services.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B, and if you cannot get premium-free Part A, we will not ask you to enroll in it.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, 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 unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or

- 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 OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, 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 unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, 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.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 14.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 14.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting, and taking medicine. (2) Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Custodial care that lasts 90 days or more is sometimes known as Long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 14.

Durable medical equipment

Durable medical equipment (DME) is equipment that is intended for repeated use, medically necessary, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, designed for prolonged use, appropriate for use in the home, and serves a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services

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

Group health coverage

Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Health care coverage purchased through membership in an organization is also "group health coverage."

Medically necessary

All benefits need to be medically necessary in order for them to be covered benefits. Generally, if your Plan physician provides the service in accord with the terms of this brochure, it will be considered medically necessary. However, some services are reviewed in advance of your receiving them to determine if they are medically necessary. When we review a service to determine if it is medically necessary, a Plan physician will evaluate what would happen to you if you do not receive the service. If not receiving the service would adversely affect your health, it will be considered medically necessary. The services must be a medically appropriate course of treatment for your condition. If they are not medically necessary, we will not cover the services. In case of emergency services, the services that you received will be evaluated to determine if they were medically necessary.

Our allowance

The amount we use to determine your coinsurance. When you receive services or supplies from Plan providers, it is the amount that we set for the services or supplies if we were to charge for them. When you receive services from non-Plan providers, we determine the amount that we believe is usual and customary for the service or supply, and compare it to the charges. Our allowance is based upon the reasonableness of the charges. If the charges exceed what we believe is reasonable, you may be responsible for the excess over our allowance in addition to your coinsurance.

Us/We

Us and we refer to Kaiser Foundation Health Plan, Inc., Northern California Region.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, 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 your FEHB coverage. These materials tell you:

- 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
- When the next open season for enrollment begins.

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.

Types of coverage available for you and your family

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 children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue 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 that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

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, or when your child under age 22 marries or turns 22.

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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB)

Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option,
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact you employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you 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 (TCC).

When you lose benefits

- **When FEHB coverage 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 spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB

coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollee*s, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/inusre.

• 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 Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. 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 or from www.opm.gov/insure. It explains what you have to do to enroll.

• Converting to individual coverage

You may convert to a non-FEHB 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 of your right to convert. 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.

• Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously

enrolled in other FEHB plans, you may also request a certificate from those plans. For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of benefits for Kaiser Foundation Health Plan, Inc., Northern California Region– 2003

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$15 per office visit	16
Services provided by a hospital:		
• Inpatient	Nothing	30
• Outpatient	Nothing	31
Emergency benefits:		
• In-area	$50 per visit	35
• Out-of-area	$50 per visit	35
Mental health and substance abuse treatment:	Regular cost sharing	36
Prescription drugs	$10 per prescription for generic drugs; $25 per prescription for brand-name drugs; all charges if you request a brand-name drug in place of a generic drug	39
Dental Care	No benefit	45
Vision Care	Refractions; $15 per office visit	21
Special features: Flexible benefits option; Services from other Kaiser Permanente Plans; Travel benefit; 24 hour nurse line; Services for deaf and hearing impaired; Centers of excellence		42
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum).....	Nothing after $1,500/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	14

Notes

2003 Rate Information for
Kaiser Foundation Health Plan, Inc., Northern California Region

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 career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

		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	591	$103.58	$34.53	$224.43	$74.81	$122.57	$15.54
Self and Family	592	$247.26	$82.42	$535.73	$178.58	$292.59	$37.09