Kaiser Foundation Health Plan of Ohio

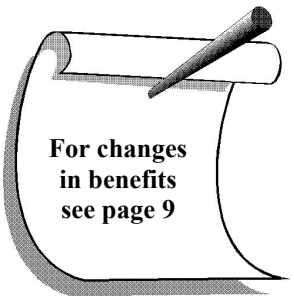
http://www.kaiserpermanente.org

KAISER PERMANENTE®

2003

A Health Maintenance Organization

Serving: *Cleveland and Akron, Ohio Metropolitan Areas*



Enrollment in this Plan is limited. You must live 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:

641 Self Only
642 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

R1 73-017

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 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 of Ohio under our contract (CS 1182) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Kaiser Foundation Health Plan of Ohio's administrative office is:

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

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 9. 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 of Ohio.

- 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 the structure of 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 us at 216/621-7100, or from other areas call 800/686-7100 or the TTY number at 877/676-6677 and explain the situation.
    - If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

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

Kaiser Foundation Health Plan of Ohio contracts with a medical group, the Ohio Permanente Medical Group, Inc. (Medical Group), for medical services. This organization may contract with other organizations to provide services, depending upon the area in which you live. We reimburse the Medical Group for these services through an annually adjusted capitation rate. This capitation payment is paid to the Medical Group as a whole for physician services provided or arranged by the Medical Group.

We also contract with other physicians and local community hospitals. These Plan providers accept a negotiated payment from us.

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.

- Kaiser Foundation Health Plan of Ohio is a federally qualified, not-for-profit health maintenance organization licensed to provide prepaid health services to Ohio residents.
- 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.
- We began offering prepaid health services to members and their families in 1969.
- We presently serve over 160,000 members in the Cleveland and Akron metropolitan areas.
- All Kaiser Permanente and affiliated hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
- All applicants for employment with the Ohio Permanente Medical Group, Inc. must meet rigorous Kaiser Permanente credentialing standards. Once hired, they undergo periodic review by peers and hospital boards to assure their credentials are up to date and in order.
- All Ohio Permanente Medical Group, Inc. physicians must be Board Eligible in their specialty and must become Board Certified within 5 years. At present, 94% are Board Certified.
- We credential Plan providers every two years and adhere to NCQA standards.

If you want more information about us, call 216/621-7100, or from other areas call 800/686-7100 or the TTY number at 877/676-6677 or write to Kaiser Foundation Health Plan of Ohio, North Point Tower, P.O. Box 5309, Cleveland, Ohio 44114. You may also visit our website at www.kaiserpermanente.org.

Service Area

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

Our service area is:

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

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

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente service area, you can receive virtually all of the benefits of this Plan at any other Kaiser Permanente facility, 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 46; and for emergency care obtained from any non-Plan provider, as described on page 36. 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 16.3% for Self Only or 19.8% for Self and Family.
- We cover home visits by a physician at no charge.
- We cover a fasting lipoprotein profile (total cholesterol, LDL, HDL, and triglycerides). We cover double contrast barium enemas as part of your colorectal cancer screening benefit.
- We reduced the number of covered visits for physical and occupational therapies from 2 consecutive months or 30 visits to 2 consecutive months or 20 visits.
- We reduced the number of covered visits for speech therapy from 2 consecutive months or 30 visits to 2 consecutive months or 20 visits.
- We offer an educational class to assist members to stop smoking.
- We cover surgery for treatment of a form of congenital hemangioma known as port wine stains on the face of members 18 years or younger.
- We cover autologous blood donations.
- We increased the copayment for outpatient hospital or ambulatory surgical center services from no charge to $10 per outpatient surgery.
- We changed the time for notification of an emergency admission to a non-Plan facility from 48 hours to 24 hours or as soon as reasonably possible.
- Copayments for group therapy for substance abuse are now no greater than $5 per day.
- We cover, at your prescription copayment, certain formulary prescription smoking cessation drugs when you enroll in and pay for a Plan authorized smoking cessation class.

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 216/621-7100 or 800/686-7100.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments 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 who we contract with to provide covered services to our members. We contract with the Ohio Permanente Medical Group, Inc. to provide physician services throughout the Cleveland and Akron metropolitan areas. The Ohio Permanente Medical Group, Inc. has referral relationships with other specialists within the community. You are referred to these specialists when necessary. In addition to the Ohio Permanente Medical Group, Inc., we have affiliations with physician networks throughout Northeast Ohio to offer you greater access and choice.

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

· Plan facilities

Kaiser Permanente offers comprehensive health care at Plan facilities conveniently located throughout the Cleveland and Akron metropolitan areas and through referral specialists, hospitals, and other providers in the community. Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members.

We list these facilities in the provider directory, which we update periodically. To get a directory, call our Customer Relations Department at 216/621-7100 or toll-free at 800/686-7100 from anywhere within the United States. The list is also on our website: www.kaiserpermanente.org.

You must receive your health care services at Plan facilities, except when you have an emergency. If you are visiting another Kaiser Permanente service area, you may receive health care services from those Kaiser Permanente facilities. Under the circumstances specified in the 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. Choose your primary care physician from our provider directory. The directory lists the physicians' addresses, phone numbers, and lets you know whether the physician is accepting new

patients. To choose or change a primary care physician, call our Customer Relations Department at 216/621-7100 or 800/686-7100. Customer Relations can help you too, by telling you who is available and sharing information about them.

· **Primary care**

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

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

- 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 Customer Relations Department immediately at 216/621-7100 or 800/686-7100. 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 benefits 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. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process precertification. Precertification is part of a process called Utilization Management. This process is used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. We do this to assist you in receiving appropriate covered medical care. Utilization Review takes place whether you receive your covered medical care from Plan providers, affiliated providers, or as the result of a Referral or a covered Emergency Service. As part of our Utilization Review, we use review criteria that are based on sound clinical evidence. These criteria are evaluated periodically to ensure ongoing efficacy. Qualified registered nurses and Plan providers perform utilization review. The review team ensures that clinical review criteria are consistently applied. The team also measures and evaluates the clinical appropriateness of adverse determinations that are subject to the disputed claims process. Individuals responsible for utilization management decisions do not receive any financial incentive or additional

compensation for such decisions. Your physician must obtain precertification for services such as:

- Hospital admissions
- Referral to specialists
- Recommendations for follow-up care
- Skilled Nursing Care
- Surgical Procedures

For a complete list of services requiring preauthorization call our Customer Relations Department at 216/621-7100 or 800/686-7100. If services are not precertified they will not be covered.

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 $10 per 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 30% of our allowance for infertility services.
• **Fees when you fail to make your copayment or coinsurance**	If you do not pay your copayment or coinsurance at the time you receive services, we will bill you. You will be required to pay a $15 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 $2,000 per person or $6,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum and you must continue to pay for these services as described in this brochure.

- Outpatient prescription drugs
- Contraceptive devices
- Dental services
- Corrective appliances and artificial aids
- Durable medical equipment
- The $25 charges paid for follow-up or continuing care outside the service area
- Reconstructive surgery
- Multidisciplinary services
- Extended care services
- Any non-FEHB benefits

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 9 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 216/621-7100 or 800/686-7100 or at 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.	IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians and other health care professionals • In a physician's office • In ambulatory surgical centers • In urgent care centers	$10 per office visit
• During a hospital stay • In a skilled nursing facility • At home by a physician	Nothing
Lab, X-ray, and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT scans/MRI • Ultrasound – Electrocardiogram and EEG Note: We cover diagnostic services related to the evaluation and treatment of infertility under our infertility services benefit.	Nothing

Preventive care, adult	You pay
Routine screenings, such as: • A fasting lipoprotein profile (total cholesterol, LDL, HDL, and triglycerides) once every 5 years for adults 20 or over • Colorectal cancer screening, including — Fecal occult blood test — Sigmoidoscopy - every five years starting at age 50 — Colonoscopy once every 10 years at age 50 — Double contrast barium enema (DCBE) once every 5-10 years at age 50 • Routine pap test • Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older Note: You should consult with your physician to determine what is appropriate for you. • 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 • Routine immunizations and boosters Note: You will still pay $10 per visit for professional services of physicians and other health care professionals.	Nothing
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance* • *Governmental licensing*	*All charges*

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics Note: You will still pay $10 per visit for professional services of physicians and other health care professionals.	Nothing
• Examinations, such as: —Eye exams through age 17 to determine the need for vision correction —Ear exams through age 17 to determine the need for hearing correction —Examinations done on the day of immunizations up to age 22 • Well-child care including routine examinations and immunizations	$10 per office visit
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: We will waive your copayment for prenatal care. Here are some things to keep in mind: • You do not need to precertify your normal delivery. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your inpatient stay will be extended if medically necessary. • 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. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We cover other care of an eligible infant who requires non-routine treatment for the first 31 days. The infant will only be covered beyond the 31 days if the infant is enrolled under a Self and Family enrollment.	$10 per office visit
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)) • Family planning services • Genetic counseling Note: We cover surgically implanted contraceptives, injectable contraceptive drugs, intrauterine devices (IUDs), and diaphragms under your prescription drug benefit.	$10 per office visit
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*
Infertility services	
• Diagnosis and treatment of infertility, such as: —Artificial insemination by intrauterine insemination (IUI) • Lab and X-ray procedures for the evaluation and treatment of involuntary infertility.	30% of our allowance per outpatient visit Nothing for inpatient
• Infertility drugs administered in the office Note: We cover oral and injectable infertility drugs under your 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 gamete intrafallopian transfer(GIFT)* • *Services and supplies related to excluded ART procedures* • *Intravaginal insemination (IVI)* • *Intracervical insemination (ICI)* • *Ovum transplants* • *Zygote intrafallopian transfer (ZIFT)* • *Services and supplies related to excluded services* • *Procurement and storage of donor eggs and semen* • *Procedures for women who have evidence of ovarian failure* • *Procedures when either member of the family has been voluntarily surgically sterilized* • *Services for surrogate mothers who are not Plan members* • *Services related to surrogate arrangements*	*All charges*

Allergy care	You pay
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: • *Sublingual allergy densitization*	*All charges*
Treatment therapies	
• Chemotherapy • Radiation therapy • Dialysis – Hemodialysis and peritoneal dialysis at approved facilities • Growth hormone therapy Note: Drugs for growth hormone therapy (GHT) are covered under our prescription drug benefit. We cover home health dialysis under our home health services benefit.	$10 per office visit
• Respiratory and inhalation therapy	Nothing
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 two consecutive months or 20 visits, whichever is greater, 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 self-care and improved functioning in other activities of daily life	$10 per outpatient visit Nothing for inpatient
Multidisciplinary rehabilitation facility services are provided up to two months per condition. Outpatient rehabilitation, including diagnostic and restorative services, provides a program of physical, speech, occupational, respiratory therapy, social and psychological services, and other items and services that are medically necessary for rehabilitation. The two month limit applies to all inpatient and outpatient comprehensive rehabilitation services you may receive for the same condition.	No charge

Physical and occupational therapies—continued on next page

Physical and occupational therapies *(continued)*	**You pay**
Not covered: • *Long-term rehabilitative therapy* • *Cognitive rehabilitative therapy* • *Cardiac rehabilitation*	*All charges*
Speech therapy	
We cover two consecutive months or 20 visits, whichever is greater, per condition for: • Speech therapy by speech therapists when medically necessary	$10 per outpatient visit Nothing for inpatient
Not covered: *Speech therapy that is not medically necessary such as:* • *Therapy for educational placement or other educational purposes* • *Training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation* • *Therapy for tongue thrust in the absence of swallowing problems*	*All charges*
Hearing services (testing, treatment, and supplies)	
Hearing tests to determine the need for hearing correction	$10 per office visit
Not covered: • *Hearing aids, examinations, and tests to determine their effectiveness* • *All other hearing testing*	*All charges*
Vision services (testing, treatment, and supplies)	
• Diagnosis and treatment of diseases of the eye • Eye refractions	$10 per office visit
Not covered: • *Corrective eyeglass lenses and frames* • *Contact lenses* • *Examinations for contact lenses and the fitting of contact lenses* • *Refractions for contact lenses* • *Eye surgery solely for the purpose of correcting refractive defects of the eye* • *Eye exercise and orthoptics*	*All charges*

Foot care	You pay
• Foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes, when prescribed by a physician	$10 per office visit
Orthopedic and prosthetic devices	
Internal prosthetic devices, such as: • Pacemakers • Artificial joints • Surgically implanted breast implant following mastectomy	Nothing
External prosthetic and orthotic devices and braces are provided under Plan criteria such as: • Breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Permanent lenses following cataract removal or congenital absence of the organic lens of the eye • Artificial limbs • Terminal devices • Braces • Appliances essential to the effective use of artificial limbs or braces • External cardiac pacemakers • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	20% of our allowance
Not covered: • *Comfort, convenience, or luxury equipment or features* • *Corrective shoes* • *Arch supports* • *Foot orthotics* • *Corsets, elastic stockings, garter belts, and other nonrigid appliances* • *Replacement or repair of prosthetic or orthotic appliances because of misuse* • *Educational training in the use of the prosthetic devices and orthotic appliances* • *Prosthetics related to the treatment of sexual dysfunction*	*All charges*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, of durable medical equipment provided under our criteria on January 1, 2002, is covered when used in your home (more than once), would not be of use to you if you were not ill or injured, and when prescribed by your Plan physician. Under this benefit, we cover: • Hospital beds • Oxygen • Wheelchairs • Crutches • Walkers • Blood glucose monitors • Commodes Note: We cover repair and replacement not caused by misuse.	20% of our allowance
Not covered: • *Deluxe equipment such as motor driven wheelchairs and beds, except when such deluxe features are necessary for the effective treatment of your condition and required in order for you to operate the equipment* • *Comfort, convenience, or luxury equipment or features* • *Physician's equipment* • *Exercise and hygienic equipment* • *Self help devices that are not medical in nature such as sauna baths or elevators* • *Experimental or research equipment* • *Replacement or repair that is needed due to misuse* • *Devices equipment and supplies related to the treatment of sexual dysfunction* • *Electronic monitors of the heart or lungs (except apnea monitors for newborns)* • *Devices to perform medical tests on blood or other bodily substances or excretions (except blood glucose monitors for insulin dependent diabetics)* • *Rental items which are no longer medically necessary must be paid for or returned*	*All charges*

Home health services	You pay
If you are homebound and reside within the service area: • You may receive home health care ordered by a Plan physician and provided by a registered nurse, practical nurse, licensed vocational nurse, or home health aide • Services include oxygen therapy, intravenous therapy and medications • Home dialysis —Hemodialysis —Intermittent peritoneal dialysis —Continuous ambulatory peritoneal dialysis • Intravenous (IV)/Infusion Therapy	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 the service area*	*All charges*

Chiropractic	You pay
You may receive up to 20 visits for chiropractic and acupuncture services. The total visit limit is 20 for any combination of chiropractic or acupuncture services. For a description of the acupuncture benefit see the next page. Chiropractic services are provided through American Specialty Health Network (ASHN). You will have direct access to a participating ASHN chiropractor without the need to obtain a Plan physician referral. Participating chiropractors are listed in the *ASHN Participating Provider Directory.* For a copy of the most recent directory call: 800/678-9133. You may phone the ASHN chiropractor you have selected for an initial examination. After the initial examination, your ASHN chiropractor is responsible for obtaining authorization from ASHN for any additional chiropractic services on your behalf. You may receive 20 visits for chiropractic services (in combination with acupuncture services) for the treatment of neuromusculoskeletal disorders. Services include: • Examinations • Adjunctive chiropractic therapy such as ultrasound, hot packs, cold packs, and electrical stimulation • Plain film X-rays and laboratory tests • Up to $50 for chiropractic appliances	$15 per office visit
Not covered: • *Any service that is not authorized or delivered by participating providers* • *Hypnotherapy, behavior training, sleep therapy, and weight programs* • *Thermography* • *Any radiologic exam other than plain film studies such as magnetic resonance imaging, CAT scans, bone scans, nuclear radiology* • *Education programs, non-medical self care or self-help or any self-help physical exercise training or any related diagnostic testing* • *Services or treatments for pre-employment physicals or vocational rehabilitation* • *Adjunctive therapy not associated with spinal, muscle or joint manipulation*	*All charges*

Alternative treatments	You pay
• Biofeedback when administered by our Mental Health Department as part of a prescribed pain management program or a treatment plan for other physical symptoms which are not responsive to the usual medical treatment methods	$10 per office visit
You may receive up to 20 visits for acupuncture and chiropractic services. The total visit limit is 20 for any combination of acupuncture or chiropractic services. For a description of the chiropractic benefit see the previous page. Acupuncture services are provided through American Specialty Health Network (ASHN). You will have direct access to a participating ASHN acupuncturist without the need to obtain a Plan physician referral. Participating acupuncturists are listed in the *ASHN Participating Provider Directory.* For a copy of the most recent directory call: 800/678-9133. You may phone the ASHN acupuncturist you have selected for an initial examination. After the initial examination, your ASHN acupuncturist is responsible for obtaining authorization from ASHN for any additional acupuncture services on your behalf. You may receive 20 visits for acupuncture services (in combination with chiropractic services) for the treatment of neuromusculoskeletal disorders, nausea, or pain syndromes. Services include: • Examinations • Adjunctive acupuncture therapy such as acupressure, moxibustion, and cupping • Plain film X-rays and laboratory tests	$15 per office visit
Not covered: • *Any service that is not authorized or delivered by participating providers* • *Hypnotherapy, behavior training, sleep therapy, and weight programs* • *Thermography* • *Any radiologic exam other than plain film studies such as magnetic resonance imaging, CAT scans, bone scans, nuclear radiology* • *Education programs, non-medical self care or self-help or any self-help physical exercise training or any related diagnostic testing* • *Services or treatments for pre-employment physicals or vocational rehabilitation* • *Adjunctive therapy not associated with acupuncture* • *All other forms of alternative treatment*	*All charges*

Educational classes and programs	You pay
Health education classes and specially ordered materials Our Health Education Department and Lifestyle Program offers a wide variety of classes to members and the public. Participants can learn how to take charge of their own health and well-being, manage their chronic conditions, give up unhealthy habits, and make positive, health enhancing changes in their lifestyle. Patient education classes, such as: • Adult Asthma Management • Adult Chronic Obstructive Lung Disease (COPD) Management • The Beat Goes On for heart patients • Diabetes Challenge Lifestyle and health promotion classes, such as: • Pregnancy Basics • Weight Watchers ™/Weight Management • Walkercise Workout • Smoking Cessation Class Other classes (including support groups) such as: • Managing Menopause • Education in the appropriate use of the Plan • Health education publications which tell you how to maintain physical and mental health and prevent illness and injury	Class fee varies
Not covered: • *All other educational programs and materials*	*All charges*

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

IMPORTANT		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 PRECERTIFICATION FOR ALL SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Pre-surgical testing • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over ideal body weight and/or 200% of his or her ideal weight according to current underwriting standards for 3 years; eligible members must be age 21-60 and meet our medical criteria • Insertion of internal prosthetic devices. See Section 5(a) - Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs). Note: Devices and drugs are covered under Section 5(f) • Other implanted time-release drugs • Treatment of burns	$10 per office visit for outpatient services Nothing for inpatient services

Surgical procedures—continued on next page

Surgical procedures *(continued)*	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Routine foot care*	*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 for treatment of a form of congenital hemangioma known as port wine stains on the face of members 18 years or younger • 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.	$10 per office visit for outpatient services Nothing for inpatient services
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	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws 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 tumors • Other surgical procedures that do not involve the teeth or their supporting structures	$10 per office visit for outpatient services Nothing for inpatient services

Oral and maxillofacial surgery—continued on next page

Oral and maxillofacial surgery *(continued)*	**You pay**
Not covered: • *Correction of malocclusion* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome* • *Dental services associated with medical treatment such as surgery and radiation treatment* • *Oral implants and transplants*	*All charges*
Organ/tissue transplants	
To receive a covered transplant you must satisfy the criteria developed by us. Transplants are 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 National Cancer Institute - or National Institutes of Health - 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.	$10 per office visit for outpatient services Nothing for inpatient services

Organ/tissue transplants —continued on next page

Organ/tissue transplants *(continued)*	**You Pay**
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial or non-human organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient)	Nothing
Professional services provided in: • Hospital outpatient department • Ambulatory surgical center • Office	$10 per office visit

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 Section 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS (except for Maternity stays).** Please refer to Section 3 to be sure which services require precertification.

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: 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 —continued 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 and blood products • The collection and storage of autologous blood for elective surgery when authorized by a Plan physician • Dressings, splints, plaster casts, and sterile tray services • Medical supplies, appliances, and equipment, including oxygen • Anesthetics including nurse anesthetist services • 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. We do not cover the dental procedures.	Nothing
Not covered: • *Personal comfort items, such as telephone, television, barber services, guest meals, and beds* • *Private nursing care* • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, and schools* • *Cord blood procurement and storage for possible future need for a yet-to-be determined member recipient* • *Any inpatient dental procedures*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay
• 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 and blood products • The collection and storage of autologous blood for elective surgery when authorized by a Plan physician • Pre-surgical testing • Medical supplies, including oxygen • Anesthetics and anesthesia service	$10 per outpatient surgery Nothing for inpatient surgery
Not covered: • *Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient*	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Up to 100 days per calendar year • When full-time skilled nursing care is necessary • Confinement in a skilled nursing facility is medically appropriate Services include: • 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	You pay
Supportive and palliative care is provided for a terminally ill member with a life expectancy of less than six months when: • You reside in the service area; and • Services are provided in the home; or • 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 six 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
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*
Ambulance	
Local professional ambulance service when medically necessary and ordered or authorized by a Plan physician	$50 per trip
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:

In a life-threatening emergency, call 911 or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are Plan member so they can notify us. You or a family member must notify us within 24 hours unless it is not reasonable to do so. It is your responsibility to be sure we have been timely notified.

Emergencies within our service area:

Emergency care is provided at Plan hospitals 24 hours a day, seven days a week.

If you reasonably believe you have a medical emergency condition and you cannot safely go to a Plan hospital, call 911 or go to the nearest hospital. However, if you reasonably believe you can safely go to a Plan hospital, call us or go to a Plan Emergency Room. The emergency telephone numbers to call us are: Cleveland area 216/445-4900; Akron area 800/686-2240. These numbers are available 24 hours per day, 7 days a week. You must return to us for follow-up care after emergency services are received within our service area.

If you are admitted to a non-Plan facility, we must be notified within 24 hours or as soon as reasonably possible. If you are hospitalized in a non-Plan facility and our physicians believe care can be better provided in a Plan designated hospital, you will be transferred when medically feasible. You can call us in Cleveland at 216/445-4900 or toll-free anywhere in the United States at 800/686-2240. Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching us would result in death, disability, or significant jeopardy to your condition.

Emergencies outside our service area:

If you are not near another Kaiser Permanente facility you may seek care at any emergency room, urgent care or physician's office for medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, you must notify us as soon as is reasonably possible. If a Plan physician believes care can be better provided in a Plan hospital, we will transfer you when medically feasible.

You may obtain emergency and urgent care from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local telephone book under "Kaiser Permanente". You may also call our Customer Relations Department at 800/686-7100. See Travel Benefits Section 5(g) for follow up care received outside the service area.

Emergency services/accidents benefits —begin on next page

Benefit Description	You pay
Emergency within our service area	
Emergency care as an outpatient or inpatient, including physicians' services • At a physician's office • At a Plan urgent care center	$10 per visit
• In a hospital emergency room Note: We waive your copayment if you are admitted to a hospital.	$50 per visit
Not covered: • *Elective care or non-emergency care*	*All charges*
Emergency outside our service area	
• At a physician's office • At an urgent care center	$10 per visit
• In a hospital emergency room	$50 per visit
• 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. We waive your copayment if you are admitted to a hospital.	The amount you would be charged if you were a member in that service area
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance, air or ground service, when medically appropriate Note: See Section 5(c) for non-emergency service.	$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 —continued on next page

Mental health and substance abuse benefits *(continued)*	**You pay**
Diagnosis and treatment of psychiatric conditions for children, adolescents, and adults. Services include: • Diagnostic evaluation • Treatment and counseling (including individual and group therapy visits) • Crisis intervention and stabilization for acute episodes • Psychological testing necessary to determine the appropriate psychiatric treatment Diagnosis and treatment of alcoholism and drug abuse. Services include: • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) Note: You may see an outpatient mental health or substance abuse provider without a referral from your primary care physician. Note: Your mental health or substance abuse 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.	$10 per office visit for individual therapy $5 per office visit for group therapy (maximum $5 per day for substance abuse benefit)
• Medication evaluation and management	$10 per office visit
• Inpatient psychiatric or substance abuse care • Hospital alternative services, such as partial hospitalization, day and night care Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan physician.	Nothing

Mental health and substance abuse benefits —continued 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

	I M P O R T A N T	**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.	I M P O R T A N T	

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

- **Who can write your prescription**. A licensed Plan physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan or affiliated pharmacy or get refills by mail. You may order refills by phone, in person or by using our Members Only website: www.kponline.org. If you use our online mail order feature, you can choose to have your medications delivered to your home or a Plan operated pharmacy. Online prescription orders must be paid in advance using a credit card.
- **We use a formulary.** Drugs are prescribed by Plan physicians and dispensed according to our drug formulary. A formulary is a list 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. These preferred drugs are included on our formulary. Non-formulary drugs will be covered when prescribed by a Plan physician when the drug is medically necessary. If you request a non-formulary drug when your physician has prescribed a substitution, the non-formulary drug is not covered. 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.** Prescription drugs will be provided up to a 31-day supply or 62-day supply for mail order. We provide up to a 31-day supply based upon (a) the prescribed dosage, (b) the standard manufacturer's package size, and (c) specified dispensing limits. Certain drugs for sexual dysfunction also have a dispensing limit less than a 31-day supply. If you ask for a mail order prescription too soon after the last one was filled, the mail order pharmacy staff will send you a letter telling you it was too soon to fill the prescription.
- **Why use generic drugs?** The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your plan less money than a name-brand drug.
- **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: • Drugs for which a prescription is required by law • Oral contraceptives and diaphragms • Insulin • Disposable needles and syringes for the administration of insulin • Growth hormones	$5 per prescription or refill for generic drugs $15 per prescription or refill for brand-name drugs
• Contraceptive devices, implanted time-release contraceptive drugs, and injectable contraceptives	$5 times the number of months the generic contraceptive is expected to be effective. The most you will pay is $200. $15 times the number of months the brand-name contraceptive is expected to be effective. The most you will pay is $200.
• Prescription smoking cessation drugs when you participate in and pay the cost of a Plan approved smoking cessation class. See Section 5(a) for education classes and programs. The drug must be prescribed by a Plan physician with prior authorization from the Plan. Coverage is limited to one course of therapy per year.	$5 per prescription or refill for generic drugs $15 per prescription or refill for brand-name drugs
• Infertility drugs • Drugs for sexual dysfunction Note: Certain drugs to treat sexual dysfunction have a dispensing limit of 8 tablets per month for a single copayment.	50% of our allowance

Covered medications and supplies —continued on next page

Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins and nutritional supplements that can be purchased without a prescription* • *Nonprescription drugs including over the counter nicotine replacement products* • *Prescriptions filled at non-Plan pharmacies, except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Drugs for non-covered services* • *Drugs for the purpose of weight loss* • *Drugs and materials that require administration by medical personnel or observation by medical personnel during or after administration* • *Replacement of lost or damaged prescriptions* • *Benzoyl peroxide products*	*All charges*

Section 5 (g). Special features

Feature	Description
24 hour emergency advice line	24 hours a day, 7 days a week, you may call 800/686-2240 and talk with a registered nurse who will help you decide your treatment options when you are not sure what to do.
Centers of Excellence	Kaiser Permanente, nationally, has a National Transplant Network that contracts with transplant centers that meet our requirements for excellence. The Centers of Excellence program began in Fall 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted "Centers of Excellence" for certain specialized medical procedures. We have developed a network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.
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. • We review alternative benefits on an ongoing basis. • 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 visit 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 copayments or other charges imposed by the Plan you are visiting. If the Plan you are visiting has a benefit that differs 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 covered if you receive them in other Kaiser Permanente service areas. If a benefit is limited to a specific number of office visits or days, you are entitled to receive only the number of visits or days covered by this Plan. If you are seeking routine, non-emergent, or non-urgent services, you should call the Kaiser Permanente Membership 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 our service area. 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 wish to obtain more information about the benefits available to you from a Kaiser Permanente Plan in an area you visit, please call our Customer Relations Department at 216/621-7100 or 800/686-7100.

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 and 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 covered services 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 visit. We deduct this amount from the payment we make to you. • We pay no more than $1200 each calendar year. • For more information about this benefit call Customer Relations at 800/686-7100. • Claims should be submitted to Kaiser Foundation Health Plan of Ohio, Claims Department, P.O. Box 5316, Cleveland, Ohio, 44101-9774. *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*

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 we pay them only when we determine they are medically necessary. • Plan dentists must provide or arrange your care. • We cover hospitalization for dental procedures only when a nondental 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 unless it is described below. • 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

Accidental injury benefit

Service	You pay
No Benefit	*All charges*

Dental benefits

Service	
No Benefit	*All charges*

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.

(VAPP) Value Added Purchasing Plans

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

Dental VAPP

Dental VAPP allows Members to purchase dental services at favorable prices from selected community dentists. Members must use one of the more than 600 selected community dentists participating in Kaiser Permanente's Dental VAPP. For a list of Delta Dental's network of dentists, please call 800/932-0783 or visit their website at www.deltadental.com.

Vision VAPP

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

Note: To qualify for discounts and savings on dental and vision VAPPS, members must present their Kaiser Permanente identification card at the time of service or purchase.

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 related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services required for (a) obtaining or maintaining employment or participation in employee programs or (b) insurance or governmental licensing;
- Services, drugs, or supplies you receive without charge while in active military service; or
- Services provided or arranged by criminal justice institutions for members confined therein.

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 may need to file a claim when you receive emergency services from non-plan providers. 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 us at 216/621-7100 or from other areas at 800/686-7100, or the TTY number at 877/676-6677.

When you must file a claim – such as for services you receive outside of the Plan's service area – submit it on 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:
Claims Administration
Kaiser Foundation Health Plan of Ohio
P.O. Box 5316
Cleveland, OH 44101-9774

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.

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 pre-authorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P.O. Box 93764, Cleveland, OH 44101-5764; 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 approval, then call us at 216/621-7100, or from other areas call 800/686-7100 or the TTY number at 877/676-6677 and we will expedite our review; or

(b) We denied your initial request for care or pre-authorization/prior approval, 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 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 is the primary payer; it pays benefits first. 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 payer 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 216/621-7100 or 800/686-7100.

(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, and also remain enrolled in our FEHB Plan. In this case, we do not waive cost-sharing for your FEHB coverage.

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 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 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. However, we now require that you assign your Medicare Part B benefits to the Plan for Plan services.

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 of Ohio.

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, however we will send you a letter notifying you when a dependent reaches the age limit. 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 Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

· **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 **800/LTC-FEDS (800/582-3337) (TDD for the hearing impaired: 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 of Ohio – 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 and other health care professionals:		
• Diagnostic and treatment services provided in the office.....	$10 per office visit	16
Services provided by a hospital:		
• Inpatient.....	Nothing	32
• Outpatient.....	$10	34
Emergency benefits:		
• In-area	$50 per visit	37
• Out-of-area	$50 per visit	37
Mental health and substance abuse treatment:	Regular cost sharing	38
Prescription drugs	$5 per prescription or refill for generic drugs $15 per prescription or refill for brand-name drugs	42
Dental Care	No benefit	47
Vision Care	Refractions; $10 per office visit	21
Special features: 24 hour emergency advice line; Centers of Excellence; Flexible benefits option; Services from other Kaiser Permanente Plans; Travel benefit		44
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $2,000/Self Only or $6,000/Family enrollment per year Some costs do not count toward this protection	14

Notes

2003 Rate Information for
Kaiser Foundation Health Plan of Ohio

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

Postal rates apply to 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	641	$102.75	$34.25	$222.62	$74.21	$121.59	$15.41
Self and Family	642	$249.62	$86.56	$540.84	$187.55	$294.70	$41.48