Kaiser Foundation Health Plan of Colorado

http://www.kaiserpermanente.org

KAISER PERMANENTE®

2003

A Health Maintenance Organization

Serving: *Metropolitan Denver, Colorado area*
Colorado Springs, Colorado area

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:

651 Self Only
652 Self and Family

Authorized for distribution by the:

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

FEHB
Federal Employees
Health Benefits Program

RI 73-019

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 Colorado under our contract (CS 1268) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Kaiser Foundation Health Plan of Colorado's administrative office is:

Kaiser Foundation Health Plan of Colorado
2500 South Havana Street
Aurora, Colorado 80014-1622

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 Colorado.
- 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 303/338-3800 in Denver/Boulder or 888/681-7878 in Colorado Springs 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

We contract with the Colorado Permanente Medical Group (Plan physicians) in the Denver/Boulder area to provide care in our Plan Medical Offices and network physicians (Plan physicians) in the Colorado Springs area. These Plan physicians are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee-for-service, and incentive payments, for services they provide and services that are referred. If you would like further information about the way we pay Plan physicians to provide or arrange medical and hospital care in your service area, please call the Customer Service Center at 303/338-3800, or for Colorado Springs members, 888/681-7878.

Your Rights

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

We are a federally qualified health maintenance organization, and we have provided health care services to the Denver, Colorado area since 1969. Kaiser Foundation Health Plan of Colorado is a Colorado not-for-profit organization. This Plan is part of the Kaiser Permanente Medical Care Program, a group of not-for-profit organizations and contracting medical groups that serve over 8 million members nationwide. Our Medical Group, the Colorado Permanente Medical Group, P.C., operates Plan medical offices in the Denver/Boulder area. For the Colorado Springs area, we offer you services through participating providers.

If you want more information about us, call our Customer Service Center at 303/338-3800 for Denver members or 888/681-7878 for Colorado Springs members, or write to Kaiser Foundation Health Plan of Colorado, Customer Service Center, 2500 South Havana Street, Aurora, Colorado 80014-1622. 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:

Denver. These zip codes in Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld counties: 80001-7, 80010-22, 80024-28, 80030-31, 80033-34, 80036-38, 80040-42, 80044-47, 80102, 80104, 80107-12, 80116-17, 80120-31, 80134-35, 80137-38, 80150-51, 80154-55, 80160-63, 80201-12, 80214-39, 80241, 80243-44, 80246-52, 80254-56, 80259-66, 80270-71, 80273-75, 80279-81, 80290-95, 80299, 80301-10, 80314, 80321-23, 80328-29, 80401-3, 80421-22, 80425, 80427, 80433, 80437, 80439, 80452-55, 80457, 80465-66, 80470-71, 80474, 80481, 80501-4, 80510, 80513-14, 80516, 80520, 80530, 80533-34, 80537-40, 80542-44, 80601-3, 80614, 80621, 80623, 80640, 80642-43, 80651.

Colorado Springs. These zip codes in Douglas, El Paso, Fremont, Park and Teller counties: 80106, 80118, 80132-33, 80808-09, 80813-14, 80816-17, 80819-20, 80827, 80829, 80831-33, 80840-41, 80860, 80863-64, 80866, 80901, 80903-22, 80925-26, 80928-37, 80940-47, 80949-50, 80960, 80962, 80970, 80977, 80995, 80997, 81007-08, 81212, 81240.

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 42; and for emergency care obtained from any non-Plan provider, as described on page 33. We will not pay for any other health care services.

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

Section 2. How we change for 2003

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

Program-wide changes

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

Changes to this Plan

- Your share of the non-Postal premium will increase by 15.1% for Self Only or 37.5% for Self and Family.
- We increased the specialty care office visit copayment to $20.
- We increased pharmacy copayments to $10 for generic drugs and $20 for brand name drugs.
- We added a $100 per admission copayment for all inpatient hospital services.
- We increased the emergency room copayment to $100 per visit.
- We reduced the copayment for each group mental health and substance abuse therapy visit from $10 to $5 per visit.
- We increased the charge for food supplements from $3 per day to $3 per product per day.
- We exclude any packaging other than the dispensing pharmacy's standard packaging.

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 our Customer Service Center. The Customer Service Center's numbers for ID issues are: Denver/Boulder: 303/338-3800, 303/338-3820 (TTY/TDD), and 800/632-9700 (toll free). In Colorado Springs, the number is: 888/681-7878. Customer Service Center hours are Monday – Friday, 8:00 a.m. – 5:00 p.m. (MST). Members with ID card issues can write to: Kaiser Foundation Health Plan of Colorado, Customer Service Center, 2500 South Havana Street, Aurora, Colorado 80014-1622.

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**

Denver/Boulder area: We contract with the Colorado Permanente Medical Group, P.C., to provide or arrange all necessary health care services. Physicians, including specialists, and other health care professionals such as nurse practitioners, physician assistants, and other skilled medical personnel working as medical teams at our Plan facilities provide your medical care. You also receive other necessary medical services, such as physical therapy, laboratory and x-ray services at our Plan facilities.

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

Colorado Springs area: We contract, through the Colorado Permanente Medical Group, P.C., with a panel of affiliated primary care physicians, specialists, and other health care professionals to provide medical services. You can identify these physicians, along with a listing of affiliated specialists and ancillary providers in the Affiliated Practitioner Directory. You may obtain a copy by calling Customer Service at 888/681-7878 or going to our website, www.kaiserpermanente.org/coloradosprings and clicking on "Affiliated Practitioner Directory."

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members.

Denver/Boulder area: Our contracted hospitals include Exempla St. Joseph's Hospital, Swedish Medical Center and Boulder Community Hospital.

We offer health care at 16 Plan medical offices conveniently located throughout the Denver/Boulder metropolitan area. We list these in the provider directory, which we update periodically. The list is also on our website.

Colorado Springs area: You may access hospital care at affiliated Plan facilities.

When you select your primary care physician, you will receive your services at that physician's office.

You must receive your health services at affiliated Plan facilities, except if you have an emergency. If you are visiting another Kaiser Permanente service area, you may receive health care services at those Kaiser Permanente facilities. Under the circumstances specified in this brochure, you may receive follow-up or continuing care while you travel anywhere.

What you must do to get covered care

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

Denver/Boulder area: Choose your primary care physician from our provider directory. If you want to receive care from a specific physician who is listed in the directory, call the physician to verify that he or she still participates with the Plan and is accepting new patients.

Colorado Springs area: Choose your primary care physician from our panel of affiliated primary care physicians. Our affiliated physicians, both primary care and specialists, are listed in the Affiliated Practitioner Directory. You may obtain a copy by calling the Customer Service Center at 888/681-7878 or by going to our website, www.kaiserpermanete.org/coloradosprings and clicking on "Affiliated Practitioner Directory".

- **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. We cover specialists' services only when your primary care physician refers you.

Note that your primary care copayment may apply to other providers, such as obstetricians and gynecologists.

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.

In Colorado Springs, you may change your primary care physician at any time. Call the Customer Service Center at 888/681-7878. Notify us of your new primary care physician choice by the 15th day of the month. Your selection will be effective on the first day of the following month.

- **Specialty care**

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

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan.

- 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, for Denver/Boulder members, call our Customer Service Center immediately at 303/338-3800, or for Colorado Springs members, 888/681-7878. 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. However, for certain services, such as oral and maxillofacial surgery, reconstructive surgery, DME, and pulmonary rehabilitation, your physician must obtain approval from us.

We call this review and approval process "preauthorization." Preauthorization is the process of collecting information so we can determine coverage, eligibility, medical appropriateness, and benefit limitations.

Preauthorization determinations are made based on the information available at the time the service or procedure is requested.

Registered nurses perform the first level of review using nationally recognized guidelines and resources, as well as our own internal guidelines and policies. The nurse coordinates with the requesting physician in evaluating the medical appropriateness of the service or procedure. The Utilization Management nurse will approve cases that meet our criteria. If the nurse is unable to approve the services based on the application of our criteria, the Medical Director will review the matter. If the Medical Director approves, you will receive the service. If the Medical Director denies the service we send a denial letter to your physician and you.

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 office visit.
- **Deductible** — We do not have a deductible.
- **Coinsurance** — Coinsurance is the percentage of our allowance that you must pay for certain services you receive. Example: In our Plan, you pay 50% of our allowance for infertility services.
- **Fees when you fail to make your copayment** — If you do not pay your copayment at the time you receive services, we will bill you. You will be required to pay a $10 charge for each bill sent for unpaid services. In Colorado Springs, affiliated physician offices may bill you an additional charge along with any unpaid copayments.

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

After your copayments and coinsurance total $2,000 per person or $4,500 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 copayments for these services.

- Prescription drugs
- Dental services
- Chiropractic services
- Extended care services
- Durable medical equipment
- External prostheses and braces
- The $25 charges paid for follow-up or continuing care outside the service area

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

Section 5. Benefits -- OVERVIEW

(See page 9 for how our benefits changed this year and page 67 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 303/338-3800 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. • Different copayments apply for primary care visits and specialty care visits. Please refer to Section 10, *Definitions*, to learn more about when your primary and specialty care copayments will apply. • Note: We waive or lower the $10 charge if you enroll in our Medicare+Choice Plan and assign your Medicare benefits to the Plan.	IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians and other health care professionals • In a physician's office • Office medical and clinical pharmacist consultations • Initial examination of a newborn child covered under a family enrollment • Second surgical option	$10 per visit to your primary care provider $20 per visit to a specialist
Professional services of physicians and other health care professionals • In a Plan urgent care center after office hours	$25 per office visit
Professional services of physicians and other health care professionals • During a hospital stay • In a skilled nursing facility	Nothing
At home	Nothing

Lab, X-ray, and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	
Routine screenings, such as: • Blood lead level • Total blood cholesterol • Colorectal cancer screening, including —Fecal occult blood test —Sigmoidoscopy - every five years starting at age 50 • Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older • Routine pap test Note: You should consult with your physician to determine what is appropriate for you. Note: You will pay only one copayment if you receive your routine screening on the same day as your office visit.	$10 per visit to your primary care provider $20 per visit to a specialist
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years Note: In addition to routine screening, we cover mammograms when medically necessary to diagnose or treat your illness.	Nothing
Routine immunizations and boosters	Nothing

Preventive Care - Adult -- continued on next page

Preventive care, adult *(continued)*	**You pay**
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance* • *Attending schools* • *Travel immunizations*	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics • 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 • Well-child care including routine examinations and immunizations	$10 per visit to your primary care provider $20 per visit to a specialist
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance* • *Attending schools or camp* • *Travel immunizations*	*All charges*
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your physician will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c) for hospital benefits and Section 5(b) for surgery benefits.	$10 per office visit
Not covered: • *Routine sonograms to determine fetal age, size, or sex*	*All charges*

Family planning	You pay
A broad range of voluntary family planning services, limited to: • Family planning services including counseling • Voluntary sterilization (See Surgical procedures Section 5(b)) Note: We cover surgically implanted time-release contraceptive drugs, injectable contraceptive drugs, intrauterine devices (IUDs), and diaphragms under the prescription drug benefit.	$10 per visit to your primary care provider $20 per visit to a specialist
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	
Medical services for diagnosis of involuntary infertility. Treatment of involuntary infertility including artificial insemination limited to intrauterine insemination (IUI).	50% of our allowance
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Intravaginal insemination (IVI)* • *Intra-cervical insemination (ICI)* • *Assisted reproductive technology (ART) procedures, such as:* *—in vitro fertilization* *—gamete and zygote intrafallopian transfer (GIFT and ZIFT)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm and donor eggs and services related to their procurement and storage* • *Drugs related to infertility treatment*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections	$10 per visit to your primary care provider $20 per visit to a specialist
Allergy serum	Nothing

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: We limit high dose chemotherapy in association with autologous bone marrow transplants to those transplants listed under Organ/tissue transplants. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis Note: We waive office visit charges if you enroll in Medicare Part B and assign your Medicare benefits to us. Note: Intravenous (IV)/Infusion Therapy – we cover home IV and antibiotic therapy and growth hormone therapy (GHT) under the Prescription Drug benefit.	$10 per visit to your primary care provider $20 per visit to a specialist
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	
Two consecutive months of therapy per condition: • Physical therapy by qualified physical therapists to restore bodily function when you have a total or partial loss of bodily function due to illness or injury • Occupational therapy by occupational therapists to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life Note: If you have not received 20 or more outpatient visits within the two-month period that started with your first visit to a therapist, we may continue your therapy for up to 20 outpatient visits per therapy per condition. Cardiac rehabilitation in a Multifit Intervention Program that provides exercise stress testing, exercise prescriptions, home self-monitored exercise and case management by registered nurses. Four educational sessions in "Cardiac College" to learn about diet, exercise, lipids, smoking cessation, and on-site monitored programs.	$10 per visit to your primary care provider $20 per visit to a specialist Nothing for inpatient
Pulmonary rehabilitation. The program consists of: • Initial evaluation • 6 education sessions • 12 exercise sessions • A final evaluation Note: You must complete the course within a two to three-month period.	$50 for the program

Physical and occupational therapies -- continued on next page

Physical and occupational therapies *(continued)*	**You pay**
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	
Two consecutive months of therapy per condition: • Speech therapy by speech therapists when medically necessary Note: If you have not received 20 or more outpatient visits within the two-month period that started with your first visit to a therapist, we may continue your therapy for up to 20 outpatient visits per therapy per condition.	$10 per visit to your primary care provider $20 per visit to a specialist 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)	
• Exam to determine the need for hearing correction • Hearing testing for children through age 17 (see Preventive care, children)	$10 per visit to your primary care provider $20 per visit to a specialist
Not covered: • *All other hearing testing* • *Hearing aids and supplies*	*All charges*
Vision services (testing, treatment, and supplies)	
• Diagnosis and treatment of diseases of the eye • Eye exam to determine the need for vision correction for children through age 17 (see Preventive care, children) • Eye refractions to provide a written lens prescription for eyeglasses only	$10 per visit to your primary care provider $20 per visit to a specialist
Not covered: • *Corrective eyeglass lenses or frames* • *Examinations for contact lenses or the fitting of contact lenses* • *Eye exercises* • *Radial keratotomy and other refractive surgery*	*All charges*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$10 per visit to your primary care provider $20 per visit to a specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails and similar routine treatment of conditions of the foot* • *Treatment of weak, strained or flat feet or bunions or spurs of any instability, imbalance or subluxation of the foot*	*All charges*
Orthopedic and prosthetic devices	
When prescribed by a Plan physician, we cover internal prosthetic devices, such as: • Artificial joints • Pacemakers • Cochlear implants • Surgically implanted breast implant following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device.	Nothing
When prescribed by a Plan physician, we cover: • Artificial legs, arms, and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	20% of our allowance
Note: We will pay no more than $2000 per year for all DME, including orthopedic and prosthetic devices. The $2000 limit does not apply to artificial arms and legs. Note: We cover only those standard items that are adequate to meet the medical needs of the member.	

Orthopedic and prosthetic devices -- continued on next page

Orthopedic and prosthetic devices *(continued)*	**You pay**
Not covered: • *Comfort, convenience, or luxury equipment or features* • *Orthopedic and corrective shoes* • *Podiatric use devices and arch supports* • *Foot orthotics* • *Dental prostheses, devices, and appliances* *Note: We will provide medically necessary orthodontic and prostho-dontic treatment for cleft lip or cleft palate for newborn members, unless these services are covered under a dental insurance policy.* • *Spare or alternate use devices* • *Replacement of lost prosthetic and orthotic devices* • *Repairs, adjustments, or replacements because of misuse* • *Devices, equipment, and prosthetics related to treatment of sexual dysfunction*	*All charges*
Durable medical equipment (DME)	
When prescribed by a Plan physician, we cover rental or purchase, at our option, of durable medical equipment intended to be used repeatedly and in the home. Covered items include: • Oxygen and oxygen equipment • Dialysis equipment • Infant apnea monitors • Insulin pumps for Type 1 diabetes • Hospital beds • Wheelchairs, including motorized wheelchairs when medically necessary • Crutches • Walkers • Commodes • Respirators • Blood glucose monitors • Repair and adjustment Note: We will pay no more than $2000 per year for all DME, including orthopedic and prosthetic devices. Oxygen and insulin pumps are not subject to the $2000 limit. When outside the service area, you must obtain your oxygen supplies and services from Apria. Note: We cover only those standard items that are adequate to meet the medical needs of the member. Note: We use a DME formulary to determine which items will be provided to members.	20% of our allowance

Durable medical equipment -- continued on next page

Durable medical equipment (DME) *(continued)*	**You pay**
Not covered: • *Comfort, convenience, or luxury equipment or features* • *Devices, equipment, supplies, and prosthetics related to the treatment of sexual dysfunction* • *Electric monitors of bodily functions* • *Devices to perform medical testing of bodily fluids, excretions, or substances* • *Devices not medical in nature such as whirlpools, saunas, elevators, convenience, or comfort items* • *Disposable supplies* • *Replacement of lost equipment* • *Repair, adjustments, or replacements because of misuse* • *More than one piece of durable medical equipment serving essentially the same function, except for replacements* • *Spare or alternate use equipment*	*All charges*
Home health services	
If you are homebound and reside in the service area: • You may receive home health services of nurses and health aides, physical or occupational therapists, and speech and language pathologists • Services include oxygen therapy, intravenous therapy, and medications	Nothing
Not covered: • *Custodial care* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Homemaker services* • *Care that a Plan physician determines may appropriately be provided at a Plan Medical Office, hospital, or skilled nursing facility* • *Services outside our service area*	*All charges*

Chiropractic	You pay
Chiropractic services, limited to 20 visits per calendar year, including: • Evaluation • Associated laboratory • X-ray services • Treatment of musculoskeletal disorders Note: You may self-refer to one of our participating chiropractors. For a list of participating chiropractors contact Columbine Health Plan at 303/825-7526 or toll free at 800/915-7526.	$15 per office visit
Not covered: • *Treatment for non-neuroskeletal disorders* • *Vocational rehabilitation services* • *Thermography* • *Transportation costs, including ambulance* • *Prescription drugs, vitamins, minerals, nutritional supplements, or other similar type products* • *MRI or other types of diagnostic radiology* • *Durable medical equipment or supplies for use in the home*	*All charges*
Alternative treatments	
No benefit	*All charges*
Educational classes and programs	
Health education services and education in the appropriate use of Health Plan services	$10 per visit to your primary care provider $20 per visit to a specialist
Health education classes, such as smoking cessation, stress reduction, or weight control	The specific charge we set for the class you select

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

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

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 • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity • Insertion of internal prosthetic devices. See Section 5(a) Orthopedic and prosthetic devices for coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs). Note: Drugs and devices are covered under Section 5(f). • Other implanted time-release drugs. Note: Drugs are covered under Section 5(f). • Treatment of burns	$50 for outpatient surgery $100 per inpatient admission

Surgical procedures -- continued on next page

Surgical procedures (*continued)*	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Implants or devices related to the treatment of sexual dysfunction*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: —the condition produced a major effect on the member's appearance; and —the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities, cleft lip, cleft palate, birthmarks, webbed fingers, and webbed toes. • Surgery for treatment of a form of congenital hemangioma known as port wine stains on the face or neck 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.	$50 per outpatient surgery $100 per inpatient admission
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	You pay
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 incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	$20 per visit with specialist $50 for outpatient surgery $100 per inpatient admission
Not covered: • *Shortening of the mandible or maxillae for cosmetic purposes* • *Correction of malocclusion* • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental care involved in treatment of the temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges*
Organ/tissue transplants	
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 Note: We cover related medical and hospital expenses of the donor when we cover your transplant.	$50 per outpatient surgery $100 per inpatient admission

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 non-human or artificial organs* • *Bone marrow transplants associated with high dose chemotherapy for other solid tissue tumors* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • Semiprivate accommodations, or when a Plan physician determines it is medically necessary, private accommodations or private duty nursing care • Specialized care units such as intensive or cardiac care units • General nursing care • Meals and special diets Note: Your physician may prescribe private accommodations or private duty nursing care if it is medically necessary. If you want at private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 per inpatient admission

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 or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 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 cover general anesthesia for dental services for a member's child due to physical, mental, or behavior problems.	$100 per inpatient admission
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals, and beds* • *Any inpatient dental procedures*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Dressings, casts and sterile trays • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Medical supplies, including oxygen • Anesthetics and anesthesia service	$50 per surgery

Extended care benefits/skilled nursing care facility benefits	You pay
Up to 100 days per calendar year • When full-time skilled nursing care is necessary • Confinement in a skilled nursing facility is medically appropriate	Nothing
Not covered: • *Custodial care* • *Care in an intermediate care facility*	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member: • You must reside in the service area • Services are provided in the home, or • 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. Special Services Program • Hospice-eligible members who have not yet elected hospice care are eligible to receive 15 home visits by Plan special service hospice providers 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 for home-based hospice services $100 per inpatient admission
Ambulance	
Local professional ambulance service when ordered or authorized by a Plan physician	$50 per transport
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. When the operator answers, stay on the phone and answer all questions.

Emergencies within our service area:

Denver/Boulder area: If you are in an emergency situation, call **911**, go to the closest emergency room or a Plan hospital. If you are not sure whether your situation is an emergency, call our Emergency Care Telephone Line at 303/861-3434, 24 hours a day, seven days a week. If an ambulance is necessary, we will authorize it.

For urgently needed services, such as an earache or sore throat with fever that cannot wait for a routine visit, you may call your PCP's Medical Office to schedule a same-day appointment during regular office hours. You may obtain urgent care services after regular office hours at various facilities in the Denver/Boulder area. Please call 303/338-3800 for information on locations and hours of accessibility for after-hours/urgent care.

Colorado Springs area: If you are in an emergency situation, call 911, or go to the closest emergency room. If you are not sure your situation is an emergency, call your PCP.

For urgent care that cannot wait for a routine office visit, call your PCP to schedule a same-day or urgent care appointment during regular office hours. Urgent/after hours care is available by calling your PCP. You can also check our website, www.kaiserpermanente.org/coloradosprings, for a listing of urgent care/after hours clinics.

Emergencies outside our service area:

We cover emergency situations, such as myocardial infarction, appendicitis or premature delivery, outside the service area. If you are hospitalized for emergency services while outside our service area, you or a family member should notify us within 48 hours or as soon as possible after you have been admitted. We will make arrangements for any necessary continued hospitalization or to transfer you to a hospital within our Plan. By notifying us as soon as possible, you will protect yourself from potential liability for payment of services you receive after a transfer would have been possible.

Note: Emergency services are limited to those services required before your medical condition permits your travel or transfer to care in our Plan. Continuing or follow-up care from out-of-plan providers is not covered.

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities are listed in the local telephone book under Kaiser Permanente. These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling Customer Service at 303/338-3800.

Benefit Description	You pay
Emergency within our service area	
Emergency care as an outpatient or inpatient at a hospital, including physicians' services • At a Plan medical office • After hours/urgent care services • In a hospital emergency room Note: Your copayment is waived if you are admitted to a Plan hospital.	 $10 per visit $25 per visit $100 per visit
Not covered: • *Elective care or non-emergency care*	*All charges*
Emergency outside our service area	
Emergency care as an outpatient or inpatient at a hospital, including physicians' services • Urgent care services • In a hospital emergency room • 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.	 $25 per visit $100 per visit The amount you would be charged if you were a member in that service area
Not covered: • *Elective care or non-emergency care* • *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 services to the nearest hospital equipped to handle your medical condition where authorized by a Plan physician. • We will authorize air ambulance if ground transportation is not medically appropriate	$50 per transport
Not covered: • *Transports that 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 not 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 • Psychiatric treatment, including group and individual therapy • Medication evaluation and management 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) • Rehabilitative care 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. Note: You may see a mental health provider for these services without a referral from your primary care physician.	$10 per individual therapy office visit $5 per group therapy office visit
• Inpatient psychiatric care • Hospital alternative services, such as partial hospitalization, day and night care, and intensive outpatient psychiatric treatment programs • Inpatient care Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan physician.	$100 per inpatient admission
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Services we have not approved* • *Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* • *Services that are custodial in nature* • *Services rendered or billed by a school or a member of its staff* • *Services provided under a federal, state, or local government program* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms*	*All charges*

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

Section 5 (f). Prescription drug benefits

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

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

- **Who can write your prescription**. A Plan or referral physician or licensed dentist (for acute conditions only) must write the prescription.
- **Where you can obtain them**.

  Denver/Boulder area: You must fill the prescription at a Plan pharmacy. You may refill prescriptions at Plan pharmacies, through Direct Rx**,** our mail order service or online. We provide refills in the same quantities as the original prescription, at the applicable brand or generic copayment, for up to a 60-day supply as prescribed. You can obtain reorder envelopes at Plan pharmacies. Envelopes are included in every order mailed by Direct Rx. Direct Rx mails refills by First Class U.S. Mail at no charge to you for postage and handling. You should receive your prescription within 7-10 days. To place an order by telephone, call Direct Rx at 303/344-5077. This refill line can be used 24 hours a day.

  You may order prescription refills online, using our Members Only website www.kponline.org. This site requires online registration. You can choose to have your prescriptions mailed to your home or to a Plan medical office pharmacy for you to pick up. Online prescription orders must be paid for in advance, by a credit card.

  Colorado Springs area: You must fill the prescription at a pharmacy designated by the Plan. A list of affiliated pharmacies can be obtained by calling our Customer Service Center at 888/681-7878 or by accessing our Colorado Springs website at www.kaiserpermanente.org/coloradosprings. You may have prescriptions for maintenance medications filled by our convenient mail-order prescription service, **ScripPharmacy**, available 24 hours a day. Refills will be mailed by First Class U.S. Mail at no charge to you for postage and handling. You should receive your prescription within 7-10 days. Contact **ScripPharmacy** customer services representatives at 800/677-4323 (TTY for deaf and hearing impaired: 877/517-9301) for more information, or check our Colorado Springs website. You may also access **ScripPharmacy's** online pharmacy to order your refills. You can access it through the "Our Services" section of our website at www.kaiserpermanente.org/coloradosprings.
- **We use a formulary**. A formulary is a listing of preferred pharmaceutical substances and formulas. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. When your physician believes a non-formulary drug is necessary, he may request a formulary exception. The physician, pharmacist, and our medical director will determine the best medication to treat your condition. If you request the non-formulary drug when your Plan physician has prescribed a generic substitution, the non-formulary drug will not be covered. However, you may purchase the non-formulary drug from a Plan pharmacy or designated pharmacies in the Colorado Springs area at our allowance.

  Note: Some prescription drugs, such as (but not limited to) Zyban or Interferon, require preauthorization in Colorado Springs. Your Plan physician should contact MedImpact, our pharmacy benefit manager, to obtain approval.
- **These are the dispensing limitations.** You may purchase covered drugs in prescribed quantities for up to a 60-day supply for maintenance drugs or part of a 60-day supply for non-maintenance drugs, except certain drugs that have a significant potential for waste will be provided for up to a 30-day supply.

Please contact our Pharmacy Call Center at 303/338-4503 for the current list of these drugs. Refills of prescriptions will be provided subject to the same conditions as the original prescription. Plan pharmacies may substitute a generic equivalent for a name-brand drug unless prohibited by the Plan physician. If a generic equivalent is not available, you pay the brand-name copayment. If you request a brand-name drug not on the formulary when your Plan physician has prescribed an approved generic drug, you pay the applicable copayment plus the difference in price between the generic drug and your requested brand-name drug.

- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original name-brand product. 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 prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below • Oral and injectable contraceptive drugs, contraceptive devices, and intrauterine devices • Insulin • Growth hormone • Niacin • Chemotherapy drugs Note: If we do not have a generic equivalent for a brand name drug, you will pay the $20 copayment.	$10 per prescription for generic drugs $20 per prescription for brand-name drugs
• Disposable needles and syringes for the administration of covered medications • Glucose test strips • Injectable hormone therapyi (in place of surgery for prostate cancer)	20% of our allowance
• Implanted time-release contraceptive drugs • Other implanted time-release drugs Note: We do not refund any portion of the copayment if you request removal of the implanted time-release medication before the end of its expected life.	A one-time payment equal to $10 times the expected number of months the medication will be effective, not to exceed $200
Food supplements and supplies, for use in the home • For individuals unable to absorb or digest food • Includes enteral and parenteral elemental dietary formulas and amino acid modified product for treatment of inborn errors of metabolism	$3 per product per day
• Drugs to treat sexual dysfunction Note: There are dispensing limitations for drugs to treat sexual dysfunction. Please contact us for details.	50% of our allowance
• Immunosuppressant drugs after a covered transplant	$20 per prescription or refill
• Intravenous fluids and medications for home use	Nothing

Covered medications and supplies -- continued on next page

Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Vitamins and nutritional supplements that can be purchased without a prescription* • *Medical supplies such as dressings and antiseptics* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs related to infertility services* • *Condoms* • *Any packaging other than the dispensing pharmacy's standard packaging* • *Replacement of lost, stolen, or damaged drugs and accessories*	*All charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit • 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

Special features -- continued on next page

Section 5 (g). Special features, *continued*

Feature	Description
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 conditions diagnosed and treated within the previous 90 days by a Kaiser Permanente health care provider or affiliated Plan provider. Services include dialysis and prescription drug monitoring • You pay $25 for each follow-up or continuing care office visit. 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 the Travel Benefit Information Line at 800/632-9700 • Claims should be submitted to the Claims Department, Kaiser Foundation Health Plan of Colorado, P.O. Box 372970, Denver, CO 80237-6970 (Denver/Boulder area) or the Claims Department, Kaiser Foundation Health Plan of Colorado, P.O. Box 378020, Denver, CO 80237-8020 (Colorado Springs) *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*
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.

Services from other Kaiser Permanente Plans -- continued on next page

Services from other Kaiser Permanente Plans *(continued)*	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 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 the Customer Service Center at 303/338-3800 in Denver/Boulder and 888/681-7878 in Colorado Springs.

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 cover 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.
- Your calendar year benefit maximum is limited to $1,000 per member.
- 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.
- For a list of participating providers, please contact Delta Dental Plan of Colorado at 303/741-9305 or 800/610-0201 and identify your EPO - Exclusive Provider Option Plan.
- Emergency services and supplies to repair sound natural teeth, due to accidental injury, are covered under and administered by Health Plan. Emergency dental procedures needed to alleviate severe pain, as described in the dental benefits listed below, are covered under your EPO Plan and administered by Delta Dental Plan of Colorado.

IMPORTANT

Accidental injury benefit	You pay
We cover emergency services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Any other services are provided as described below.	$100 per inpatient admission $10 for outpatient services

Dental benefits begin on the next page

Dental Benefits

Service	You pay
Diagnostic	
Initial Exam	$ 10.00
Periodic Exam	Nothing
Emergency Exam	18.00
Full Mouth X-Rays	35.00
1 Intraoral Xray	6.00
Additional Intraoral Xray	4.00
Occlusal Xray	10.00
Bitewing	5.00
2 Bitewings	11.00
3 Bitewings	11.00
4 Bitewings	15.00
Panoramic Film	28.00
Cephalometric Film	27.00
Pulp Tests	11.00
Diagnostic Casts	26.00
Service	
Preventive	
Prophylaxis Adult	$ 5.00
Prophylaxis Age 0-14	5.00
Topical Fluoride W/Prophy	16.00
Top Fluoride Child No Prophy	5.00
Top Fluoride Adult No Prophy	5.00
Sealant - Per Tooth	9.00
Spacer Fixed Unilateral	85.00
Spacer Fixed Bilateral	130.00

Dental benefits -- continued on next page

Dental Benefits *(continued)*

Service	You pay
Restorative	
Amalgam 1 Surface Primary	$ 29.00
Amalgam 2 Surface Primary	36.00
Amalgam 3 Surface Primary Amalgam 1	45.00
Surface Permanent	34.00
Amalgam 2 Surface Permanent	44.00
Amalgam 3 Surface Permanent	55.00
Amalgam 4 Surf/Plus Permanent	66.00
Anterior Resin 1 Surface	40.00
Anterior Resin 2 Surfaces	52.00
Anterior Resin 3 Surfaces	64.00
Porc/High Noble Metal Crown	365.00
Porc/Predom Base Metal Crown	312.00
Porc/Noble Metal Crown	348.00
Full High Noble Metal Crown	358.00
Full Predom Base Metal Crown	298.00
Full Noble Metal Crown	340.00
3/4 Metallic Crown	350.00
Recement Crown	26.00
Prefab Stainless Steel Crown Primary	76.00
Sedative Filling	26.00
Crown Buildup Pin Retained	75.00
Pin Retention Excl Of Restoration	16.00
Cast Post & Core In Add To Crown	118.00
Prefab Post & Core No Crown	95.00
Service	
Endodontics	
Therapeutic Pulpotomy	$ 45.00
Root Canal Anterior	195.00
Root Canal Bicuspid	230.00
Root Canal Molar	310.00
Apicoectomy Anterior	190.00
Apicoectomy Bicuspid	230.00
Apicoectomy Molar	235.00

Dental benefits -- continued on next page

Dental Benefits *(continued)*

Service	You pay
Periodontics	
Gingivectomy Per Quad	$ 148.00
Gingivectomy Per Tooth	58.00
Gingival Curettage Per Quad	144.00
Gingv Flap W/Root Pl-Per Quad	250.00
Osseous Surgery Per Quad	640.00
Perio Root Plan Per Quad	84.00
Maintenance Following Therapy	44.00
Service	
Prosthodontics	
Complete Upper Denture	$ 423.00
Complete Lower Denture	423.00
Comp Immediate Upper Denture	455.00
Comp Immediate Lower Denture	455.00
Partial Upper Denture/Metal Base	490.00
Partial Lower Denture/Metal Base	490.00
Repair Broken Complete Denture	55.00
Replace Missing/Broken Teeth	50.00
Repair/Replace Broken Clasp	72.00
Replace Tooth on Denture	50.00
Add Tooth to Partial Denture	60.00
Add Clasp to Partial Denture	72.00
Lab Reline Upper Denture	95.00
Lab Reline Lower Denture	95.00
Cast High Noble Metal Pontic	360.00
Cast Predom Base Metal Pontic	265.00
Cast Noble Metal Pontic	280.00
Porcelain With High Noble Metal Pontic	375.00
Porcelain Predom Base Metal Pontic	260.00
Porcelain Noble Metal Pontic	275.00
Porcelain High Noble Metal Crown	380.00
Porcelain Predom Base Metal Crown	265.00
Porcelain Noble Metal Crown	355.00
Full High Noble Metal Crown	370.00
Full Predom Base Metal Crown	250.00
Full Noble Metal Crown	285.00
Cast Pore & Core No Bridge Retainer	100.00
Prefabricated Post & Core No Bridge	80.00
Retainer Crown Build-Up	65.00

Dental benefits -- continued on next page

Dental Benefits *(continued)*	
Service	**You pay**
Oral Surgery	
Single Tooth Extraction	$ 38.00
Additional Tooth Extraction	34.00
Root Removal Exposed Tooth	48.00
Surgery Extraction/Erupted Tooth	74.00
Rem Imp Tooth-Soft Tissue	85.00
Rem Imp Tooth-Partially Bony	110.00
Rem Imp Tooth-Completely Bony	130.00
Surgical Root Recovery	75.00
Service	
Adjunctive Services	
Palliative Treatment	$ 30.00
Consultation	27.00
Emergency dental benefit – outside service area only	All amounts over $50
Not covered: • *Cosmetic dental services* • *Replacement of lost or stolen dentures or bridgework* • *Orthodontic services* • *Dental services not listed as covered*	*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.

As an FEHBP enrollee in this Plan, you can receive acupuncture and massage therapy services through Landmark Healthcare, at a 25% discount of the practitioner's standard charges. Contact Landmark Healthcare at 800/638-4557 for more information.

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, drugs, or supplies you receive without charge while in active military service; or
- Services provided or arranged by criminal justice institutions for federal 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 will only need to file a claim when you receive emergency services from non-plan providers or when you use the travel benefit. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital, and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 303/338-3600 in Denver/Boulder and 888/681-7878 in Colorado Springs.

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

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

Submit your claims to:

Denver/Boulder area:
Claims Department
Kaiser Foundation Health Plan of Colorado
P.O. Box 372970
Denver, CO 80237-6970

Colorado Springs area:
Kaiser Foundation Health Plan of Colorado
c/o Meridian
6200 Canoga Avenue
Woodland Hills, CA 91367

Deadline for filing your claim

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

When we need more information

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

If you have a malpractice claim

If you have a malpractice claim because of services you did receive, or did not receive, from a Plan provider, you must submit the claim to binding arbitration. The Plan has the information that describes the arbitration process. Contact our Compliance and Risk Management Department at 303/344-7298 for copies of our requirements. These will explain how you can begin the binding arbitration process.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for 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: Compliance and Risk Management Department, Kaiser Foundation Health Plan of Colorado, P.O. Box 378066, Denver, CO 80237-8066; 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 303/338-3800 in the Denver/Boulder area and 888/681-7878 in the Colorado Springs area 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 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 303/338-3800.

(Primary payer chart begins on next page.)

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

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

- **Medicare managed care plan**

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

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

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan, known as Medicare+Choice or Kaiser Permanente Senior Advantage, and also remain enrolled in our FEHB plan. (This Plan is available in the Denver/Boulder area only. It is not available in the Colorado Springs area.) There is no additional premium to enroll in Senior Advantage. In this case, we waive or lower some of our copayments and coinsurance for your FEHB and Medicare coverage. If you would like information about our Medicare+Choice plan, please call 303/338-3800. Your Kaiser Permanente Senior Advantage-FEHBP benefits that we lowered or waived are:

- Outpatient office visits: $5
- Preventive care office visits: $0
- Short-term speech, occupational, and physical rehabilitative therapy: $5
- Outpatient mental health office visits: $5
- Dialysis services: $0
- Family planning services: $5
- Infertility treatment: $5
- Substance abuse treatment: $5

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 lower or 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 enroll in Medicare Part B**

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

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

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

TRICARE and CHAMPVA

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

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

Copayment

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

Covered services

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

Custodial care

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

Deductible

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

Durable medical equipment

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

Experimental or investigational services

We carefully evaluate whether a particular therapy is safe and effective or offers a reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental literature. When the service or supply, including a drug: (1) has not been approved by the FDA; or (2) is the subject of a new drug or new device application on file with the FDA; or (3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or (4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or (5) is subject to the approval or review of an Institutional Review Board; or (6) requires an informed consent that describes the service as experimental or investigational; then this Plan considers that service, supply, or drug to be experimental, and not covered by the Plan.

Group health coverage

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

Medically necessary

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

Our allowance

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

Primary care copayment

The copayment for your primary care visit is $10 for the following services: internal medicine, obstetrics and gynecology, pediatric, and family practice services.

Specialty care copayment

The copayment for your specialty care visit is $20. This copayment applies when you receive services from medical providers who are not primary care physicians (as defined above).

Us/We

Us and we refer to Kaiser Foundation Health Plan of Colorado.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

Types of coverage available for you and your family

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children

live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

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

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

When benefits and premiums start

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

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can 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 Colorado – 2003

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$10 per primary care visit $20 per specialty care visit	16
Services provided by a hospital:		
• Inpatient	$100 per admission	30
• Outpatient	$50 per surgery	31
Emergency benefits:		
• In-area	$100 per visit	34
• Out-of-area	$100 per visit	34
Mental health and substance abuse treatment:	Regular cost sharing	35
Prescription drugs	$ 10 per prescription for generic drugs; $ 20 for brand name	39
Dental Care	Various copayments based on procedure rendered	44
Vision Care	One refraction annually; $10 per office visit	21
Special features: Flexible benefits option; Travel benefit; Services from other Kaiser Permanente Plans		41
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum).....	Nothing after $2,000/Self Only or $4,500/Family enrollment per year Some costs do not count toward this protection	14

Notes

2003 Rate Information for
Kaiser Foundation Health Plan of Colorado

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	651	$100.73	$33.58	$218.26	$72.75	$119.20	$15.11
Self and Family	652	$249.62	$102.26	$540.84	$221.57	$294.70	$57.18