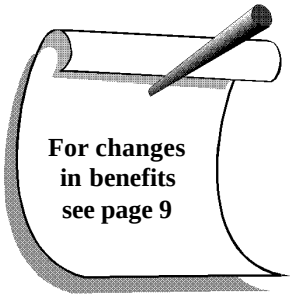
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

http://www.kaiserpermanente.org

KAISER PERMANENTE®
Kaiser Foundation Health Plan
of the Mid-Atlantic States, Inc.

2003

A Health Maintenance Organization



Serving: *Metropolitan Washington, DC Area and Metropolitan Baltimore, Maryland Area*

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

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

Enrollment codes for this Plan:

E31 Self Only
E32 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 73-047

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 the Mid-Atlantic States, Inc., under our contract (CS 1763) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.'s administrative office is:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20852

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 the Mid-Atlantic States, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area, and explain the situation. Our TTY telephone number is 301/879-6380.
    - 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 benefits from non-Plan providers (while you travel) 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 pay the Mid-Atlantic Permanente Medical Group, P.C., the Affiliated Primary Care Physician's Network (APCPN) located in Baltimore, Maryland, Affiliate Columbia Gateway (AFCG), APS Healthcare, Maryland Eye Care, Dental Benefit Providers, and contracted community specialists and ancillary providers to provide your medical, surgical, mental health, substance abuse, ophthalmology, optometry, and dental services. We contract with local community hospitals to provide hospitalization services. These Plan providers accept a negotiated payment from us.

Your Rights

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

- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente), is a federally qualified Health Maintenance 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.
- Kaiser Permanente is a Maryland non-profit corporation licensed in the Commonwealth of Virginia, the District of Columbia and the State of Maryland.
- Kaiser Permanente began delivering prepaid healthcare services to Washington, DC residents in December 1972.
- Kaiser Permanente presently serves approximately 525,000 members in the Washington, DC and Baltimore, Maryland metropolitan areas.
- Kaiser Permanente credentials its Plan providers in accord with national standards.

If you want more information, call us at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380. Write to us at Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Attention: Member Services Department, 2101 E. Jefferson Street, Rockville, Maryland, 20852 or by fax at 301/816-6192. You may visit our website at http://www.kaiserpermanente.org.

Service Area

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

- **The District of Columbia**

- **The following Virginia counties:**
  - Arlington
  - Fairfax
  - Loudoun
  - Prince William

- **The following Virginia cities**:
  - Alexandria
  - Falls Church
  - Fairfax
  - Manassas
  - Manassas Park

- **The following Maryland counties:**
  - Anne Arundel
  - Baltimore
  - Carroll
  - Harford
  - Howard
  - Montgomery
  - Prince Georges

  Portions of the following Maryland counties, as indicated by the zip codes below, are also within the service area:
  - Calvert – 20639, 20678, 20689, 20714, 20732, 20736, and 20754 zip codes only
  - Charles – 20601, 20602, 20603, 20604, 20612, 20616, 20617, 20637, 20640, 20643, 20646, 20658, 20675, 20677, and 20695 zip codes only
  - Frederick – 21701, 21702, 21703, 21704, 21705, 21709, 21710, 21714, 21716, 21717, 21718, 21754, 21755, 21758, 21759, 21762, 21769, 21770, 21771, 21774, 21775, 21777, 21790, 21792, and 21793 zip codes only

- **Baltimore City, MD**

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente service area, you can receive virtually all of the benefits of this Plan at any other Kaiser Permanente facility, including our mail order prescription program. You must pay the charges or copayments imposed by the Kaiser Permanente Plan you are visiting, with the exception of mail order prescriptions which are administered by your home Plan. See Section 5(g), Special Features, for more details. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described on page 46; and for emergency care obtained from any non-Plan provider, as described on page 36. We will not pay for any other health care services.

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

Section 2. How we change for 2003

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

Program-wide changes

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

Changes to this Plan

- Your share of the non-Postal premium will increase by 15.1% for Self Only or 10.9% for Self and Family.
- We increased the office visit copayment for specialty care visits from $10 to $20. Primary care visits, (i.e., family practice, gynecology, obstetrics, internal medicine, and pediatrics) will remain at a $10 copayment. Specialty care services include all other services.
- We cover travel consultations, immunizations, and vaccines.
- We decreased the number of visits for outpatient physical therapy to 30 visits or 60 days of coverage (whichever is greater).
- Eye refractions for eyeglasses are no longer limited to one per year.
- We added coverage for Continuous Positive Airway Pressure (CPAP) equipment for 20% of our allowance for the first three months and 50% of our allowance for every 30 days thereafter.
- We cover the procurement and storage of medically necessary cord blood for a known recipient.
- We increased the copayment for outpatient surgery from $10 to $50.
- We limit the supply of injectable drugs that are self-administered to a 30-day supply.
- We added the option to obtain covered medications and supplies at participating network pharmacies at $20 per prescription or refill for generic drugs or $40 per prescription or refill for brand-name drugs.
- We changed the copayment for disposable needles and syringes and glucose test strips to 20% of our allowance.

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), your Employee Express confirmation letter, or write to us at Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., ATTN: Member Services Correspondence, 2101 E. Jefferson St., Rockville, MD 20852. Members may submit inquiries, requests and complaints through our website http://www.kp.org/locations/midatlantic/index.html. A Member Services representative will work with you to answer questions and resolve issues, including ID card issues.

If you do not receive your ID card within 30 days after we have received your enrollment from your payroll office, or if you need replacement cards, call us at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380.

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, except for emergency, urgent care services outside our service area, and for covered services while you travel.

- **Plan providers**

Our Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We contract with the Mid-Atlantic Permanente Medical Group, P.C., to provide or arrange for primary care services and specialty care services for our members.

Our Provider Directory lists the Plan providers, with locations and phone numbers. Directories are updated annually and are available at the time of enrollment. However, our online Provider Directory is updated biweekly. Our website address is http://www.kaiserpermanente.org.

- **Plan facilities**

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

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.

Our Provider Directory lists the Plan facilities. Directories are updated annually and are available at the time of enrollment. However, our online Provider Directory is updated biweekly. Our website address is http://www.kaiserpermanente.org.

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.

To choose a primary care physician you can either select one from our Provider Directory, on our website is http://www.kaiserpermanente.org or you can call us at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380. We are happy to assist you in selecting a primary care physician.

· **Primary care**

We require you to choose a primary care physician when you enroll. Your primary care physician can be an internal medicine physician, an obstetrician/gynecologist, a pediatrician, or a family practice physician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

· **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. You may see an optometrist or our mental health and substance abuse Plan providers without a referral. Members may obtain mental health and substance abuse services without a primary care referral by directly calling KPMAS' Behavioral Health Access Unit at 866/530-8778 to arrange for services.

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 work with the specialist, in consultation with you, to 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, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

· **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380.

If you are new to the FEHB Program, we will arrange for you to receive care. If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan,

whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process precertification. Your physician must obtain precertification for the following services:

- Acupuncture
- All inpatient services, except maternity
- Adenoids or tonsil removal
- Breast surgery not associated with cancer
- Carpal tunnel surgery
- Chiropractic services
- Clinical trials
- Durable medical equipment
- Gastric bypass surgery
- Home health care
- Hospice care

- Hysterectomy
- Infertility treatment
- Infusion therapy
- Injectable medications
- MRI
- Nasal surgery
- Occupational therapy
- Oral surgery
- Organ transplants
- Pain clinics
- Physical therapy
- Pulmonary therapy
- Prosthetics
- Reconstructive surgery
- Sclerotherapy for varicose veins
- Speech therapy
- Spinal surgery not associated with cancer
- Sleep studies
- Surgical procedures
- Temporomandibular Joint surgery
- Tubes in the ears

Requests for these services are made to your primary care physician just like any other referral. Your primary care physician submits the request, with supporting documentation. It takes an average of 2 working days to process the request. You should call your primary care physician's office if you have not been notified of the outcome of the review within 5 working days. If your request is not approved, you have a right to appeal by calling inside the Washington, DC Metropolitan area at 301/468-6000 or toll free at 800/777-7902. Our TTY is 301/879-6380. After business hours, for urgent situations, you may call Appointments/Advice to request an appeal at 703/359-7878, 800/777-7904, TTY is 301/879-7616 or 800/700-4901. If you wish additional services, you must make the request to your primary care physician.

Emergency services do not require precertification. However, you or your family member must notify the Plan within 48 hours, or as soon as reasonably possible.

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, ovulation stimulants, weight management drugs, smoking cessation drugs, and oxygen and equipment for home use after the first three months.
• **Fees when you fail to make your copayment or coinsurance**	If you do not pay your copayment or coinsurance at the time you receive services, we will bill you. You will be required to pay a $10 charge for each bill sent for unpaid services.

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

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

- Prescription drugs
- Chiropractic and acupuncture services
- Dental services
- Follow-up and continuing care outside the service area
- Infertility services
- Any non-FEHB benefits

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

Section 5. Benefits – OVERVIEW

(See page 9 for how our benefits changed this year and page 76 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, claim filing advice, or more information about our benefits, contact us at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380. You can also visit 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. • 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. • We have no calendar year deductible.	IMPORTANT

Benefit Description	You Pay
Diagnostic and treatment services	
Professional services of physicians and other health care professionals • In a physician's office • In an urgent care center • Second surgical opinion	$10 per visit to your primary care provider (except nothing for children from infancy through age 4) $20 per visit to a specialist
• During a hospital stay • In a skilled nursing facility Note: See Section 5 (c) for facility charges.	Nothing
At home (in the service area)	Nothing
Lab, X-ray, and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap smears • Pathology • X-rays • Non-routine mammograms • CAT scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Preventive care, adult	You Pay
Routine screenings, such as: • Total blood cholesterol • Colorectal cancer screening, including —Fecal occult blood test —Sigmoidoscopy - every five years starting at age 50 • Bone mass measurement for prevention, diagnosis and treatment of osteoporosis • Routine Prostate Specific Antigen (PSA) test- one annually for men age 40 and older • Chlamydia screenings – women under age 20 who are sexually active and women over age 20 with multiple risk factors • Routine pap smear • Travel Consultations Note: You should consult with your physician to determine what is appropriate for you. Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster - once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over • Travel immunizations and vaccines Note: You pay only one copayment if you receive your routine screening or immunization 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 to 39, one during this five-year period • From age 40 to 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Participating in employee programs* • *Insurance or licensing* • *Court ordered for parole or probation* • *Attending schools*	*All charges*

Preventive care, children	You Pay
• Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: —Eye exams to determine the need for vision correction —Ear exams to determine the need for hearing correction • Travel Consultations • Travel immunizations and vaccines	Nothing for primary care office visits for infancy through age 4 $10 per visit to your primary care provider from age 5 up to age 22
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Participating in employee programs* • *Insurance or licensing* • *Court ordered for parole or probation* • *Attending schools*	*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 do not need to precertify your normal delivery. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your inpatient stay will be extended if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We cover other care of an infant who requires non-routine treatment only if the infant is covered under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 for the first office visit to confirm pregnancy Nothing once pregnancy is confirmed through the post-partum office visit
Not covered: • *Routine sonograms to determine fetal age, size, or sex*	*All charges*

Family planning	You Pay
• Family planning services, including counseling • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Information on birth control • Genetic counseling 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*	*All charges*
Infertility services	
Diagnosis and treatment of involuntary infertility • Artificial insemination —intravaginal insemination (IVI) —intra-cervical insemination (ICI) —intrauterine insemination (IUI) • Fertility Drugs Note: We cover injectable fertility drugs under the prescription drug benefit.	50% of our allowance
• In vitro fertilization, (limited to three (3) attempts per live birth) if: —your oocytes are fertilized with your spouse's sperm; —you and your spouse have a history of infertility of at least 2 years duration; or —the infertility is associated with endometriosis, exposure in utero to diethylstilbestrol, commonly known as DES, blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy, or abnormal male factors, including oligospermia, contributing to the infertility; —you have been unable to become pregnant through a less costly infertility treatment for which coverage is available under the Plan	50% of our allowance; Plan pays up to $100,000 in a Member's lifetime

Infertility services – continued on next page

Infertility services *(continued)*	**You Pay**
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Assisted reproductive technology (ART) procedures, such as:* *—gamete intrafallopian transfer (GIFT)* *—zygote intrafallopian transfer (ZIFT)* • *Donor semen and donor eggs, including retrieval of eggs* • *Storage and freezing of eggs* *Note: Infertility services are not available when either member of the family has been voluntarily surgically sterilized.*	*All charges*
Allergy care	
• Testing and treatment • Allergy injection Note: Allergy serum is covered in full as a part of the office visit copayment.	$10 per visit to your primary care provider $20 per visit to a specialist
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Respiratory and inhalation therapy • Intravenous/Infusion Therapy Note: We cover growth hormone therapy (GHT) under the prescription drug benefit. • Qualified medical clinical trials that provide treatment for life-threatening conditions or for preventive, early detection, or treatment studies of cancer for Phases I, II, III and IV • Dialysis – Hemodialysis and peritoneal dialysis • 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.	$10 per visit to your primary care provider $20 per visit to a specialist

Treatment therapies – continued on next page

Treatment therapies *(continued)*	**You Pay**
Not covered: • *Long term rehabilitative therapy* • *Cognitive therapy* • *Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered* • *Sleep therapy* • *Thermography and related services*	*All charges*
Physical and occupational therapies	
Inpatient Services – up to 2 consecutive months of therapy per condition: • Physical therapy by a qualified Plan therapist in consultation with a Plan physician to restore bodily function when you have a total or partial loss of bodily function due to illness or injury • Occupational therapy by a Plan therapist in consultation with a Plan physician to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life • We provide inpatient multidisciplinary rehabilitation in a prescribed, organized program in a plan facility or skilled nursing facility for up to two consecutive months for all covered rehabilitation services and supplies you may receive at different sites for the same condition Note: This $100 charge is waived if you have been admitted directly from a hospital inpatient stay.	$100 per admission
Outpatient physical and occupational therapy • We cover up to 30 office visits or 60 days (whichever is greater) per condition of out-patient physical therapy services • We cover up to 90 days per condition of out-patient occupational therapy services Habilitative services for children – from birth to age 19 for the treatment of congenital and generic birth defects • We cover services to help a child function age-appropriately within his or her environment and enhance his or her functional ability without an effective cure	$10 per visit to your primary care provider $20 per visit to a specialist
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Cognitive rehabilitation programs* • *Vocational rehabilitation programs* • *Therapies done primarily for education purposes, except as may otherwise be covered above* • *Cardiac rehabilitation*	*All charges*

Speech therapy	You pay
Inpatient Services – up to 2 consecutive months of therapy per condition: • Speech therapy by a Plan therapist in consultation with a Plan physician when medically necessary Note: This $100 charge is waived if you have been admitted directly from a hospital inpatient stay.	$100 per admission
Outpatient Services –up to 90 days per condition per year of outpatient speech therapy Habilitative services for children – from birth to age 19 for the treatment of congenital and generic birth defects • We cover services to help a child function age-appropriately within his or her environment and enhance his or her functional ability without an effective cure	$10 per visit to your primary care provider $20 per visit to a specialist
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* • *Voice therapy for occupation or performing arts*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Hearing tests to determine the need for hearing correction	$10 per visit to your primary care provider $20 per visit to a specialist
• Hearing aids for children under age 18	All charges in excess of $1400 for each hearing impaired ear every 36 months
Not covered: • *Hearing aids, tests to determine their effectiveness, and examinations for them for all persons age 18 and over* • *All other hearing testing*	*All charges*
Vision services (testing, treatment, and supplies)	
• Eye exam to determine the need for vision correction • Eye refractions • Diagnosis and treatment of diseases of the eye	$10 per visit to your primary care provider $20 per visit to a specialist

Vision services (testing, treatment, and supplies) – continued on next page

Vision services (testing, treatment, and supplies) *(continued)*	**You Pay**
• Eyeglass frames purchased at Plan Optical Shops • Eyeglass lenses purchased at Plan Optical Shops	75% of our allowance
• Initial fitting for contact lenses at a Plan facility • Insertion and removal of contact lens training • Three months of follow-up office visits Note: These services are provided only in conjunction with obtaining your first set of contact lenses at a Plan Optical Shop.	85% of our allowance
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism* • *Cosmetic contact lenses* • *Cost of eyewear not purchased at Plan facilities* • *Sunglasses without corrective lenses*	*All charges*
Foot care	
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$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 for conditions of the foot, except as stated above* • *Treatment of weak, strained, or flat feet or bunions or spurs; and of any instability, imbalance, or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Externally worn breast prostheses and surgical bras including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device.	20% of our allowance

Orthopedic and prosthetic devices – continued on next page

Orthopedic and prosthetic devices *(continued)*	**You Pay**
• One hair prosthesis if your hair loss results from chemotherapy or radiation treatment for cancer	All charges in excess of $350
Not covered: • *Comfort, convenience, or luxury equipment or features* • *External prosthetics and orthotics, such as braces, foot orthotics, artificial limbs, and lenses following cataract removal* • *Devices, equipment, supplies, and prosthetics related to sexual dysfunction* • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose and other supportive devices*	*All charges*
Durable medical equipment (DME)	
We cover prescribed DME for home use for up to three months from the date of discharge following: • An authorized hospital admission • An authorized skilled nursing facility admission • An authorized rehabilitation facility admission • An authorized outpatient surgical procedure Covered items include: • Hospital beds • Wheelchairs • Canes • Walkers • Portable commodes • Crutches • Insulin pumps and supplies • Bilirubin lights and apnea monitors for infants up to age 3 for a period not to exceed 6 months	20% of our allowance

Durable medical equipment (DME) – continued on next page

Durable medical equipment (DME) *(continued)*	**You Pay**
• Continuous Positive Airway Pressure (CPAP) equipment • Oxygen and equipment for home use Note: Your Plan physician must recertify your medical need for oxygen and equipment every 30 days.	20% of our allowance for the first three months; 50% of our allowance for every 30 days thereafter
• Asthmatic equipment (spacers, peak-flow meters, and nebulizers) for adults and children, when purchased at a Plan pharmacy. Note: We decide whether to rent or purchase the equipment, and we select the vendor. We will repair the equipment without charge, unless the repair is due to loss or misuse. You must return the equipment to us or pay us the fair market price of the equipment when it is no longer prescribed.	Spacers: $5 per spacer Peak-Flow Meters: $10 per meter Nebulizers: $30 per nebulizer
Not covered: • *Oxygen tents* • *Motorized wheelchairs* • *Comfort, convenience, or luxury equipment or features* • *Exercise or hygiene equipment* • *Non-medical items such as sauna baths or elevators* • *Modifications to your home or car* • *Devices for testing blood or other body substances (glucose test strips are covered under your prescription drug benefits)* • *Electronic monitors of bodily functions, except apnea monitors and blood glucose monitors* • *Disposable supplies* • *Replacement of lost equipment* • *Repairs, adjustments, or replacements necessitated by misuse* • *More than one piece of durable medical equipment serving essentially the same function, except for replacements other than those necessitated by misuse or loss* • *Devices, equipment, supplies, and prosthetics for the treatment of sexual dysfunction disorders* • *External and internally implanted hearing aids for all persons age 18 and over* • *Experimental or research equipment* • *Dental appliances*	*All charges*

Home health services	You Pay
If you are homebound and reside in the service area, we cover home health care ordered by a Plan physician and provided by a registered nurse, licensed practical nurse, licensed vocational nurse, physical therapist, occupational therapist, speech and language pathologist, or home health aide • Services include oxygen therapy, intravenous therapy, and medications Note: Your Plan physician will periodically review the home health program for continuing appropriateness and medical need.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Custodial care* • *Homemaker services* • *Services outside the service area* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *General maintenance care of colostomy, ileostomy, and ureterostomy* • *Medical supplies or dressings applied by you or a family caregiver* • *Care that a Plan physician determines may be provided in a Plan facility or skilled nursing facility if we provide or offer to provide that care in one of those facilities* • *Transportation and delivery service costs of durable medical equipment, medications, drugs, medical supplies, and supplements to the home* • *Personal care items*	*All charges*
Chiropractic	
Chiropractic services, including spinal manipulation of the neck and back, up to 20 visits per calendar year, for the following services: • Evaluation and management • Routine chiropractic x-rays provided in the chiropractor's office • Chiropractic adjustments • Adjunctive therapies (e.g., hot and cold packs) • Educational materials Note: You receive these services when your Plan physician, in consultation with the Complementary and Alternative Medicine Department, determines that such care will result in improvement in your condition.	$15 per office visit

Chiropractic – continued on next page

Chiropractic *(continued)*	**You Pay**
Not covered: • *Structural supports* • *Nutritional supplements*	*All charges*
Alternative treatments	
Acupuncture services up to 20 visits per calendar year, for the following services: • Evaluation and management Note: You receive these services when your Plan physician, in consultation with the Complementary and Alternative Medicine Department, determines that such care will result in improvement in your condition.	$15 per office visit
Not covered: • *Herbal and nutritional supplements*	*All charges*
Educational classes and programs	
• Health education for conditions such as diabetes, post-coronary, and nutritional counseling	$10 per visit to your primary care provider $20 per visit to a specialist
• General health education classes such as Lamaze, weight control, smoking cessation, and stress management.	Nominal fees ranging from $10 to $50 per class
Not covered: • *Educational classes and programs not offered through this Plan*	*All charges*

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

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • Plan physicians must provide or arrange your care. • 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. • We have no calendar year deductible. • The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). • YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.	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 -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns • Insertion of surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs). Note: We cover the cost of these devices under the prescription drug benefit (see Section 5(f)) • Insertion of other implanted time-release drugs. Note: We cover the cost of these devices under the prescription drug benefit (see Section 5(f)).	$20 per visit to a specialist, $50 per outpatient surgery, or $100 per inpatient admission

Surgical procedures – continued on next page

Surgical procedures *(continued)*	**You Pay**
Not covered: • *Reversal of voluntary sterilization* • *Routine foot care; see Foot care*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: —it produced a major effect on the member's appearance; and —the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities, cleft lip, cleft palate, birth marks, web fingers, and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: —surgery to produce a symmetrical appearance on the other breast; —treatment of any physical complications, such as lymphedemas; and —breast prostheses and surgical bras and replacements (see Prosthetic devices). Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$20 per visit to a specialist, $50 per outpatient surgery, or $100 per inpatient admission
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance and/or treat a mental condition 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 to a specialist, $50 per outpatient surgery, or $100 per inpatient admission
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) except as covered under the accidental dental benefit.* • *Shortening of the mandible or maxillae for cosmetic purposes and correction of malocclusion.*	*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, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, breast cancer, multiple myeloma and epithelial ovarian cancer	$20 per visit to a specialist, $50 per outpatient surgery, or $100 per inpatient admission

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You Pay**
• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas After referral to a transplant facility, the following apply: unless otherwise authorized by your physician, transplants are covered only at institutions that we designate as "Centers of Excellence" for that specific transplant. If your physician or the transplant facility determines that you do not satisfy the criteria for receiving the transplant, we will pay only for the covered services and supplies you receive before you are notified of that determination. Limited Benefits: Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses for a living donor when those expenses are directly related to your covered transplant.	
Not covered: • *Donor screening tests and donor search expenses, except screening blood tests and advanced testing performed for the actual donor* • *Implants of non-human or artificial organs* • *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 remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- 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).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS (except for Maternity stays).** Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You Pay
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Medically necessary special duty nursing • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 per 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, X-rays, and pathology services • Procurement and storage for approved medically necessary cord blood for a designated recipient • Administration of blood and blood products • Blood or blood plasma, if donated or replaced • Dressings, splints, plaster casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take home items • Hospitalization for inpatient foot treatment Note: You may receive covered medical hospital services for certain dental procedures if a Plan physician determines that 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.	$100 per admission
Not covered: • *Custodial care* • *Non-covered facilities* • *Personal comfort items, such as telephone, television, barber services, guest meals, and beds* • *Private nursing care* • *Whole blood and packed red blood cells not replaced by member* • *Procurement and storage for possible future need or for yet to be determined Member recipient* • *Any inpatient dental procedures*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Procurement and storage of cord blood for approved medically necessary procedures requiring cord blood for a designated recipient • Administration of blood and blood products • Blood and blood plasma, if donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	$50 per outpatient surgery

Outpatient hospital or ambulatory surgical center – continued on next page

Outpatient hospital or ambulatory surgical center *(continued)*	**You Pay**
Not covered: • *Whole blood and packed red blood cells not replaced by the member* • *Procurement and storage for possible future need or for yet to be determined Member recipient*	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate. We cover the following: • Physician and nursing services • Room and board • Medical social services • Administration of blood, blood products, and derivatives • Durable medical equipment ordinarily furnished by a skilled nursing facility, including oxygen-dispensing equipment and oxygen • Respiratory therapy • Biological supplies • Medical supplies Note: We waive the additional $100 charge if you are admitted to an extended care or skilled nursing facility directly from a hospital inpatient stay.	$100 per admission
Not covered: • *Custodial care* • *Care in an intermediate facility*	*All charges*

Hospice care	You Pay
Supportive and palliative care for a terminally ill member • You must reside in the service area • Services are provided in your home, or • Services are provided in a Plan approved hospice facility Services include inpatient care, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less. Note: Hospice is a program for caring for the terminally ill that emphasizes supportive services, such as home care and pain control, rather than curative care of the terminal illness. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, physician services, and short-term inpatient care for pain control and acute and chronic symptom management. We also provide counseling and bereavement services for the individual and family members, and therapy for purposes of symptom control to enable the person to continue life with as little disruption as possible. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.	Nothing
Not covered • *Independent nursing* • *Homemaker services*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

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 the local emergency system (e.g., the local 911 telephone system). When the operator answers, stay on the phone and answer all questions. If you are not sure whether you are experiencing a medical emergency, please contact our Emergency Line at 800/677-1112.

Emergencies within our service area:

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

If you think you have a medical emergency condition and you cannot safely go to a Plan Hospital, call 911 or go to the nearest hospital. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify us within 48 hours, or as soon as is reasonably possible, by calling 703/359-7878 inside the Washington, DC metropolitan area or toll free 800/777-7904. Our TTY is 800/700-4901.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in non-Plan facilities and Plan physicians believe care can be better provided in a Plan Hospital, we will transfer you when medically feasible, with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or as soon as is reasonably possible. If a Plan physician believes care can be better provided in a Plan Hospital, we will transfer you when medically feasible, with any ambulance charges covered in full.

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local telephone book under Kaiser Permanente. These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling the Membership Services department at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380.

Benefit Description	You Pay
Emergency within our service area	
• Emergency care at a physician's office • Emergency care at a Plan urgent care center	$10 per visit to your primary care provider $20 per visit to a specialist
• Emergency care in a hospital emergency room Note: Your hospital emergency room visit copayment is waived if you are admitted to a Plan Hospital. Your $100 inpatient copayment will apply.	$50 per visit
Not covered: • *Elective care or non-emergency care*	*All charges*
Emergency outside our service area	
• Emergency care at a physician's office • Emergency care at an urgent care center	$10 per visit to your primary care provider $20 per visit to a specialist
• Emergency care in a Kaiser Foundation hospital in another Kaiser Foundation Health Plan service area • Emergency care in a non-Plan hospital emergency room Note: We waive your hospital emergency room visit copayment if you are admitted to a Plan Hospital. Your $100 inpatient copayment will apply. See the Travel Benefit for coverage of continuing or follow-up care.	$50 per visit
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 service, including air ambulance, when approved by the Plan. Note: See Section 5(c) for non-emergency ambulance service.	Nothing

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

IMPORTANT		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 are payable 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.

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

Mental health and substance abuse benefits – continued on next page

Mental health and substance abuse benefits *(continued)*	**You pay**
Diagnosis and treatment of psychiatric conditions, mental illness, or disorders of children, adolescents, and adults. Outpatient services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Psychological testing necessary to determine the appropriate psychiatric treatment • Outpatient psychiatric treatment (including individual and group therapy visits) • 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) as part of intensive outpatient programs • Intensive day treatment • Methadone treatment Note: You may see a Plan provider for outpatient treatment without a referral from your primary care physician. Note: Your Plan provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you.	$10 per visit to your primary care provider $20 per visit to a specialist
• Inpatient psychiatric care • Inpatient detoxification • Acute inpatient substance abuse rehabilitation • Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan physician. Inpatient services will only be part of a treatment plan when services cannot be provided safely on an outpatient basis or in a less intensive setting than an acute care hospital.	$100 per admission
• Hospital alternative services: partial hospitalization, intensive outpatient psychiatric treatment programs and residential crisis services	$20 per visit or $100 per admission if your treatment is more than 24 continuous hours

Mental health and substance abuse benefits – continued on next page

Mental health and substance abuse benefits *(continued)*	**You pay**
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Services we have not approved* • *Intelligence, IQ, aptitude ability, learning disabilities, 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* • *Marital, family, or educational services* • *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 that may be present*	*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 page 43. • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	IMPORTANT	

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

- **Who can write your prescription.** A Plan physician, authorized provider or licensed contracted dentist must write the prescription.

- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, an affiliated network pharmacy, or by the Plan mail order delivery service for a maintenance medication. We will pay for prescriptions written by a non-Plan physician and filled at a non-Plan pharmacy only when the prescription was given during a hospital emergency room visit or an urgent care visit outside the service area.

- **We use a formulary.** Our drug formulary is a list of prescribed drugs and accessories that have been approved by our Pharmacy and Therapeutics Committee for our Members. Unless otherwise specified by your Plan physician or dentist, generic drugs may be used to fill prescriptions.

  Our Pharmacy and Therapeutics Committee, which is comprised of Plan physicians, Plan providers, and our pharmacists, selects prescription drugs and accessories for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. In addition, the Committee sets dispensing limitations in accord with therapeutic guidelines based on the medical literature and research. The Pharmacy and Therapeutics' Committee meets periodically to consider adding and removing prescribed drugs and accessories on the formulary.

  If you request a non-formulary drug – when your physician feels there is an acceptable formulary alternative – you will be responsible for the full cost of that drug.

  However, if your Plan physician believes that a non-formulary drug best treats your medical condition; a formulary drug has been ineffective in the treatment of your medical condition; or a formulary drug causes or is reasonably expected to cause a harmful reaction, then an exception process is available to your Plan physician. In that case, your standard brand or generic prescription drug copayment would apply.

  If you would like information about whether a particular drug or accessory is included in our drug formulary, please visit us on line at www.kaiserpermanente.org, or call our Member Services Department at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380.

- **These are the dispensing limitations.** We provide up to a 60-day supply for one brand or generic copayment at a Plan or affiliated network pharmacy based upon (a) the prescribed quantity, (b) the standard manufacturer's package size, and (c) specified dispensing limits. Maintenance medications may be obtained for up to a 90-day supply for one brand or generic copayment when ordered through our Plan's mail order program. Injectable drugs that are self-administered and dispensed from the pharmacy are limited to a 30 day supply.

- **Why use generic drugs?** Kaiser Permanente providers have successfully included the use of generic drugs as part of patient care without compromising quality. Generic drugs offer a safe and economic way to meet your medication needs. They are less expensive than brand name drugs - therefore you may reduce your out-of-pocket costs by choosing to use a generic drug. Generic drugs must contain the same active ingredients and be equivalent in strength and dosage to the original brand name product. The U.S. Food and Drug Administration and also Kaiser Permanente set criteria for the use of generic drugs to ensure that they meet the same standards of purity, strength and quality as brand-name drugs. They are expected to have the same therapeutic effect as the brand name product. Not all drugs have a generic equivalent. If a generic drug is unavailable, the standard brand copayment will apply.

- **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. To file a claim, you should contact the Plan's Member Services Department at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area and obtain a claim form. Our TTY is 301/879-6380. A claim for reimbursement must be submitted to the Plan within 12 months after you purchased the prescribed drugs.

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, an affiliated network pharmacy or through our mail order program: • Drugs for which a physician's prescription is required by law • Insulin (up to six (6) vials) • Disposable needles and syringes for the administration of covered medications • Contraceptive drugs • Intrauterine devices (IUDs) and diaphragms • Implanted time-release contraceptive drugs • Other implanted time-release drugs • Injectable contraceptive drugs • Self-injectable drugs, other than ovulation stimulants • Self-administered chemotherapeutic drugs and oral chemotherapeutic agents • Growth hormone therapy (GHT) - for treatment of children with growth hormone deficiency Note: Compounded preparations must contain at least one ingredient requiring a prescription.	\$10 per prescription or refill for generic drugs or \$20 per prescription or refill for brand-name drugs if you get your prescription filled at a Plan medical center pharmacy \$8 per prescription or refill for generic drugs or \$18 per prescription or refill for brand-name drugs if you get your prescription filled through our mail order delivery system \$20 per prescription or refill for generic drugs or \$40 per prescription or refill for brand-name drugs if you get your prescription filled at an affiliated network pharmacy
• Post-surgical immunosuppressant outpatient drugs required as a result of a covered transplant • Intravenous fluids and medications for home use • Clinically administered chemotherapy drugs	Nothing
• Amino acid modified products used to treat congenital errors of amino acid metabolism (PKU)	25% of our allowance
Diabetic supplies when purchased at a Plan pharmacy • Glucose meter • Replacement batteries • Control solutions • Lancets • Disposable needles and syringes (up to 3 boxes) • Glucose test strips (up to six (6) boxes of 50 count) Note: Lancets, disposable needles and syringes, and glucose test strips are available by mail order or through Plan Pharmacies. Other diabetic supplies in this section are available only at Plan pharmacies.	 \$10 per meter \$5 per package \$8 per package \$8 per package 20% of our allowance 20% of our allowance

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	**You pay**
• Smoking cessation products are provided for one course of therapy per calendar year, when: —prescribed by Plan provider —you are in a formal smoking cessation program • Weight management drugs for morbid obesity • Drugs for covered infertility treatments • Drugs for sexual dysfunction Note: Drugs to treat sexual dysfunction have dispensing limitations. Please contact the Plan for details.	50% of our allowance
Not covered: • *Drugs obtained at either a non-Plan pharmacy or non-affiliated network pharmacy except for emergencies inside and outside the service area* • *Drugs or supplies for cosmetic purposes* • *Vitamins and nutritional supplements that can be purchased without a prescription* • *Nonprescription drugs* • *Prescription drugs for which there is a nonprescription equivalent available* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Drugs related to non-covered infertility services* • *Drugs for non-covered services* • *Dental prescriptions other than those prescribed for pain relief or antibiotics* • *Replacement prescriptions necessitated by theft, loss, or damage*	*All charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 703/359/7878 inside the Washington, DC metropolitan area or 800/777-7904 outside the Washington, DC metropolitan area or call our TTY at 703/359-7616 or 800/700-4901 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	For any of your health concerns, 24 hours a day, 7 days a week, you may call 703/359-7616 inside the Washington, DC metropolitan area or 800/700-4901 outside the Washington, DC metropolitan area and talk with a registered nurse who will discuss treatment options and answer your health questions. During regular business hours Monday through Friday, you may contact our Member Services Department with any questions concerning the Plan and how to obtain services by calling 301/879-6380.
Centers of Excellence	The Centers of Excellence program began in Fall 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted "Centers of Excellence" for certain specialized medical procedures. We have developed a national contract network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.

Travel benefit	Kaiser Permanente's travel benefits for Federal employees provide you with outpatient follow-up or continuing medical care when you are temporarily outside your home service area by more than 100 miles or outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency and urgent care benefits and include: • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast. • Outpatient continuing care for covered services for conditions diagnosed and treated within the previous 90 days by a Kaiser Permanente health care provider or affiliated Plan provider. Services include dialysis and prescription drug monitoring. • You pay $25 for each follow-up or continuing care office visit. This amount will be deducted from the payment we make to you. • Your benefit is limited to $1200 each calendar year. • For more information about this benefit you should contact the Plan's Member Services Department at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY is 301/879-6380. • File claims as shown on page 59. *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 are visiting in the service area of another Kaiser Permanente plan, you are entitled to receive virtually all the benefits described in this brochure (including our mail order prescription program) at any Kaiser Permanente medical office or medical center. You must pay the charges or copayments imposed by the Kaiser Permanente Plan you are visiting, with the exception of mail order prescriptions which are administered by your home Plan. You will have to pay the charges imposed by the Plan you are visiting. If the Plan you are visiting has a benefit that is different from the benefits of this Plan, you are not entitled to receive that benefit.

Some services covered by this Plan, such as artificial reproductive services and the services of specialized rehabilitation facilities, will not be available in other Kaiser Permanente service areas. If a benefit is limited to a specific number of visits or days, you are entitled to receive only the number of visits or days covered by the Plan in which you are enrolled.

If you are seeking routine, non-emergent, or non-urgent services, you should call the Kaiser Permanente 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 the service area of this Plan. If you require emergency services as the result of unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care.

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

If you plan to travel to an area with another Kaiser Permanente plan, and wish to obtain more information about the benefits available to you from the Kaiser Permanente plan, please call Membership Services at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY is 301/879-6380.

Section 5 (h). Dental benefits

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

Dental Benefits	You pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) your sound natural teeth that you have injured as the result of an external force (not chewing). A sound natural tooth is one that has not been weakened by existing dental pathology such as, decay or periodontal disease, or previously restored with a crown, inlay, onlay or porcelain restoration, or treatment by endodontics. Note: You must start to receive services within 60 days of your accident and complete them within 12 months of your accident. You are only covered for the most cost effective procedure that will produce a satisfactory result.	$10 per visit to your primary care provider $20 per visit to a specialist All charges in excess of $2,000 per member per accident
Not covered: • *Injuries to non-sound natural teeth* • *Services required after the 12-month period* • *Services that are needed, but did not start until later than 60 days after the accident* • *Services for teeth that have been so severely damaged that restoration is impossible, in the opinion of the Plan dental provider* • *Services for teeth that have been knocked-out*	*All charges*

Other dental benefits	You pay
We cover general anesthesia and associated hospital or ambulatory surgery facility charges in conjunction with dental care provided by a fully accredited specialist in pediatric dentistry, fully accredited specialist in oral and maxillofacial surgery, or a dentist for whom hospital privileges has been granted, for the following members: • Children, 7 years of age or younger, who are developmentally disabled, for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition, for whom a superior result can be expected from dental care provided under general anesthesia • Children, 17 years of age or younger, and extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred; and whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity • Adults, age 17 and older, whose medical condition requires that dental service be performed in a hospital or ambulatory surgical center for their safety (e.g., heart disease and hemophilia)	$100 per inpatient admission $10 per visit to your primary care provider $20 per visit to a specialist $50 per outpatient surgery
Not covered: • *The dentist's or specialist's professional services* • *Dental care for temporal mandibular joint (TMJ) disorders*	*All charges*

Discounted Fee - Dental Benefits

Kaiser Permanente has entered into an Agreement with Dental Benefit Providers, Inc. ("DBP"), under which DBP will provide or arrange for the administration of covered dental services to you through Participating Dental Providers.

- All procedures listed in the following schedule of dental services and fees are covered dental services. When you receive any of the listed procedures from a Participating Dental Provider, you will pay the fee listed next to the procedure description for that service. The Participating Dental Provider has agreed to accept that fee as payment in full for that procedure. Neither Kaiser Permanente nor DBP are liable for payment of these fees or for any fees incurred as the result of receipt of non-covered dental services.

- You will pay a fixed rate of $30 per office visit for procedures with an "FC30" fee indication in the schedule below. We waive the $5 sterilization fee for any office visit in which FC30 applies. "NB" indicates there is no benefit available and you must pay the full cost of these services.

- You may select a Participating Dental Provider, who is a "general dentist," from whom you will receive covered dental services. With a large network of general dentists in our service area, you may select a general dentist from our Dental Provider Directory for yourself and your family. You can obtain a Dental Provider Directory by calling our Member Services Department at 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY is 301/879-6380.

- Specialty care is also available should further covered services be necessary; however, you must be referred to a Participating Dental Provider who is a specialist by your general dentist. Your discounted fees are slightly higher for care received by a Participating Dental Provider who is a specialist. Please refer to the following schedule of dental services and fees for those discounted fees.

- When a dental emergency occurs outside our service area, Kaiser Permanente will reimburse you for the reasonable charges, less any discounted fee, upon proof of payment, not to exceed $50 per incident. We cover emergency dental treatment required to alleviate pain, bleeding, or swelling. If post-emergency care is required, you must receive all post-emergency care from your Participating Dental Provider.

The schedule for dental services and fees are:

Dental Benefits		**You Pay**	
ADA CODE	**PROCEDURE NAME**	**TO DENTIST**	**TO SPECIALIST**
Diagnostic Services			
00120	Periodic Oral Exam (every 6 months)	FC30	NB
00140	Ltd Oral Evaluation – Problem Focused	FC30	NB
00150	Comprehensive Oral Examination	FC30	NB
00210	Intraoral-Complete Series Including Bitewings	34	37
00220	Intraoral-Periapical-First Film	FC30	9
00230	Intraoral-Periapical-Each Additional Film	FC30	9
00240	Intraoral Occlusal Film	FC30	9
00270	Bitewing-Single Film	FC30	9
00272	Bitewing- Two Films	FC30	9
00273	Bitewing – Three Films	FC30	16
00274	Bitewing – Four Films	FC30	25
00330	Panoramic Film	28	31
00460	Pulp Vitality Tests	FC30	16
00470	Diagnostic Casts	FC30	NB
Preventive Services			
01110	Prophylaxis Adults (Every six months)	FC30	NB
01120	Prophylaxis Child (Every six months)	FC30	NB
01201	Topical Fluoride Incl Proph <16 yrs every 6 mos	FC30	NB
01203	Topical Fluoride Excl Proph <16 yrs every 6 mos	FC30	NB

Dental Benefits		You Pay	
ADA CODE	PROCEDURE NAME	TO DENTIST	TO SPECIALIST
01330	Oral Hygiene Instruction	FC30	NB
01351	Sealant –Per Tooth – To age 16	17	NB
01510	Space Maintainer – Fixed Unilateral	184	NB
01515	Space Maintainer – Fixed Bilateral	184	NB
01520	Space Maintainer – Removable Unilateral	226	NB
01525	Space Maintainer – Removable Bilateral	141	NB
01550	Recementation of Space Maintainer	21	NB
Restorative Services			
02110	Amalgam – One Surface Primary	27	NB
02120	Amalgam – Two Surfaces Primary	35	NB
02130	Amalgam – Three Surfaces Primary	39	NB
02131	Amalgam – Four or More Surfaces Primary	50	NB
02140	Amalgam – One Surface Permanent	30	NB
02150	Amalgam – Two Surfaces Permanent	41	NB
02160	Amalgam – Three Surface Permanent	51	NB
02161	Amalgam – Four or More Surfaces Permanent	60	NB
02330	Resin – One Surface Anterior	37	NB
02331	Resin – Two Surfaces Anterior	51	NB
02332	Resin –Three Surfaces Anterior	52	NB
02335	Resin >3 Sur or Inv Incisal Angle Ant	66	NB
02385	Resin - One Surface, Posterior Permanent	35	NB
02386	Resin - Two Surfaces, Posterior Permanent	56	NB
02387	Resin - 3 or More Surfaces, Posterior Permanent	70	NB
02510	Inlay-Metallic-One Surface	307	NB
02520	Inlay-Metallic-Two Surfaces	334	NB
02530	Inlay-Metallic-Three Surfaces	371	NB
02540	Onlay-Metallic-Per T In Add to Inlay	408	NB
02610	Inlay-Porcelain/Ceramic-One Surface	498	NB
02620	Inlay-Porcelain/Ceramic – Two Surfaces	498	NB
02630	Inlay-Porcelain/Ceramic – Three Surfaces	498	NB
02640	Onlay-Porc/Ceramic-Per Tooth + Inlay	498	NB
02650	Inlay-Compos/Resin-1 Surf (Lab Proc)	498	NB
02651	Inlay-Compos/Resin-2 Surf (Lab Proc)	498	NB
02652	Inlay-Compos/Resin-3 or More Surf (Lab)	498	NB
02710	Crown-Resin-Laboratory	235	NB
02740	Crown-Porcelain/Ceramic Substrate	526	NB
02750	Crown-Porcelain Fused to Hi Noble Metal	531	NB
02751	Crown-Porcelain Fused to Predom Base Mental	472	NB
02752	Crown-Porcelain Fused to Noble Metal	502	NB
02790	Crown-Full Cast High Noble Metal	510	NB
02791	Crown-Full Cast Predom Base Metal	442	NB
02792	Crown-Full Cast Noble Metal	465	NB
02810	Crown-3/4 Cast Metallic	521	NB
02910	Recement Inlay	34	NB
02920	Recement Crown	34	NB
02930	Prefab Stainl Stl Crown-Prim Tooth	101	NB
02931	Prefab Stainl Stl Crown-Perm Tooth	106	NB
02932	Prefabricated Resin Crown	157	NB
02940	Sedative Fillings	34	NB
02950	Crown Buildup (Substructure) w/pins	101	NB
02951	Pin Reten-Per Tooth in Add to Rest	22	NB
02952	Cast Post & Core In Add to Crown	146	NB
02954	Prefab Post & Core in Add to Crown	129	NB

Dental Benefits		You Pay	
ADA CODE	PROCEDURE NAME	TO DENTIST	TO SPECIALIST
02970	Temporary Crown (Fractured Tooth)	84	NB
02980	Crown Repair	84	NB
Endodontic Services			
03110	Pulp Cap-Direct Excl Final Rest	22	NB
03120	Pulp Cap-Indirect Excl Final Rest	22	NB
03220	Therapeutic Pulpotomy Exc Fin Rest	62	67
03310	RC Ther – Ant Exc Final Restoration	253	319
03320	RC Ther-Bicuspid Exc Final Restoration	294	496
03330	RC Ther – Molar Exc Final Restoration	313	614
03346	Retreatment of Prev RC Ther - Anterior	NB	378
03347	Retreatment of Prev RC Ther - Bicuspid	NB	584
03348	Retreatment of Prev RC Ther - Molar	NB	732
03350	Apexification/Recalc Per Trmt Visit	118	164
03410	Apicoectomy/Periradicular Surg-Ant	148	381
03421	Apico/perirad Surg-Bicus First Root	148	465
03425	Apico/Perirad Srg-Molar First Root	148	487
03426	Apico/Perirad Srg-Molar Ea Add Root	49	185
06430	Retrograde Filling Per Root	104	196
03450	Root Amputation-Per Root	104	252
03920	Hemisect W Rt Rem-Wo Root Canal Therapy	125	224
Periodontic Services			
04210	Gingivectomy/Gingivoplasty-Per Quad	222	297
04211	Gingivectomy/Gingivoplasty-Per Tooth	59	90
04220	Ging Curettage Surg/Quad-By Report	67	140
04240	Gingival Flap Incl Rt Health Plan-Per Quad	222	381
04249	Crn Lengthn-Hard/Soft Tissue by Rep	260	358
04250	Muco-Gingival Surgery-Per Qdrant	260	370
04260	Oss Surg Inc Flap Ent, Grafts & Clos	371	661
04261	Osseous Graft	185	330
04262	Osseous Graft Multiple	185	330
04268	Guid Tis Rgen Inc Sur Re-Ent by Rep	358	358
04270	Pedicle Soft Tissue Graft Procedure	178	420
04271	Free Soft Tissue Graft & Donor Site	260	510
04320	Provisional Splinting – Intracoronal	106	130
04321	Provisional Splinting – Extracoronal	74	134
04341	Perio Scaling/Root Health Planing-Per Quad	71	140
04355	FM Debridmt before Comp Trmt	67	140
04910	Perio Maint After Active Ther	45	67
Prosthetics - Removable			
05110	Complete Denture – Upper	525	NB
05120	Complete Denture – Lower	525	NB
05130	Immediate Denture – Upper	525	NB
05140	Immediate Denture – Lower	525	NB
05211	Upper Part Dent-Resin Base Incl Clsp	381	NB
05212	Lower Part Dent-Resin Base Incl Clsp	470	NB
05213	Up Part Dent-Met Base, Res SDL Incl Clsp	567	NB
05214	Lo Part Dent-Met Base, Res SDL Incl Clsp	567	NB
05281	Uni Part Dent-Met Base, Cast Clsp	269	NB
05410	Adjust Dent-Comp or Part, Upr or Lwr	73	NB
05510	Repair Broken Complete Denture Base	56	NB
05520	Repl Miss/Brkn T-Compl Den-Ea T	45	NB
05610	Repair Acrylic Saddle or Base	56	NB
05620	Repair Cast Framework	62	NB

Dental Benefits		You Pay	
ADA CODE	PROCEDURE NAME	TO DENTIST	TO SPECIALIST
05630	Repair or Replace Broken Clasp	50	NB
05640	Replace Broken Teeth-Per Tooth	50	NB
05650	Add Tooth to Existing Part Denture	73	NB
05660	Add Clasp to Existing Part Denture	101	NB
05710	Rebase Dnt-Comp or Par, Upr or Lower	196	NB
05730	Reline Dnt-Comp or Part, Chair	134	NB
05750	Reline Dent-Comp or Part, Lab	148	NB
05820	Temp Part Stayplate-Upper or Lower	207	NB
05850	Tissue Conditioning Upper – Denture	50	NB
05851	Tissue Conditioning Lower –Denture	56	NB
Prosthetics - Fixed			
06210	Pontic-Cast High Noble Metal	525	NB
06211	Pontic-Cast Predom Base Metal	484	NB
06212	Pontic-Cast Noble Metal	459	NB
06240	Pontic-Porc Fused to Hi Noble Metal	493	NB
06241	Pontic-Porc Fused to Predom Base Metal	431	NB
06242	Pontic-Porc Fused to Noble Metal	465	NB
06520	Inlay-Metallic-Two Surfaces	353	NB
06530	Inlay-Metallic – 3 or More Surfaces	392	NB
06540	Only – Metallic Per Tooth + Inlay	431	NB
06545	Rtain-Cast Mtl For Acide Etch Brdg	224	NB
06750	Crown-Porc Fused to Hi Noble Metal	504	NB
06751	Crown-Porc Fused to Predom Bse Metal	420	NB
06752	Crown-Porc Fused to Nobel Metal	454	NB
06780	Crown-3/4 Cast High Noble Metal	476	NB
06790	Crown-Full Cast High Noble Metal	537	NB
06791	Crown-Full Cast Predom Base Metal	478	NB
06792	Crown-Full Cast Noble Metal0	465	NB
06930	Recement Bridge	39	NB
Oral Surgery			
07110	Single Tooth	47	53
07120	Each Additional Tooth	41	47
07130	Root Removal – Exposed Roots	28	39
07210	Surgical Removal of Erupted Tooth	59	106
07220	Rem Impacted Tooth-Soft Tissue	52	129
07230	Rem Impacted Tooth-Part Bony	67	162
07240	Rem Impacted Tooth – Compl Bony	111	190
07250	Surg Rem Resid T Roots-Cutting Proc	59	106
07260	Oroantral Fistula Closure	170	213
07270	Tooth Reimplantation	104	241
07280	Surg Expos Imp/Unerup T-Ortho	125	207
07281	Surg Expos Imp/Unerup T-Aid Erup	88	168
07285	Biopsy of Oral Tissue-Hard**	74	129
07286	Biopsy of Oral Tissue-Soft**	74	112
07291	Transseptal Fiberotomy	34	34
07310	Alveolopl In Conj w Extrac-Per Quad	59	118
07320	Alveolopl No Extract-Per Quad	74	134
07410	Rad Exc-Lesion to 1.25cm**	88	168
07420	Rad Exc-Lesion over 1.25cm**	141	286
07430	Exc Benign Tumor-Lesion to 1.25cm**	111	179
07431	Exc Benign Tumor-Lesion over 1.25cm**	140	281
07450	Rem Odont Cyc/Tum-Les to 1.25cm	105	170
07451	Rem Odont Cyst/Tum-Les over 1.25cm	140	281

Dental Benefits		You Pay	
ADA CODE	PROCEDURE NAME	TO DENTIST	TO SPECIALIST
07460	Rem NonOdont Cyst/Tum-Les to 1.25cm	111	179
07461	Rem NonOdont Cyst/Tum-Les over 1.25cm	148	297
07470	Rem Exostosis-Maxilla or Mandible	193	280
07480	Part Ostectomy Gutter or Sauceriz	281	281
07510	I&D Abscess-Intraoral Soft Tissue	59	78
07520	I&D Abscess-Extraoral Soft-Tissue	59	78
07530	Rem Foreign Body/Skn/Subcut Areo Tissue	120	179
07550	Sequestrectomy for Osteomyelitis	162	162
07910	Suture Simple Wounds up to 5cm	39	39
07911	Suture of Complex Wounds up to 5cm	78	78
07960	Frenectomy Frenec/Frenot-Sep Proc	91	196
07970	Exc of Hyperplastic Tissue-Per Arch	56	148
07971	Excision of Periocoronal Gingiva	67	95
Additional Procedures			
09110	Palliative Treatment	28	NB
09210	Local Anesthesia	0	NB
09220	General Anesthesia-First 30 Minutes	74	185
09221	General Anesthesia-Each Add'l 15 Minutes	37	123
09230	Analgesia (per 30 Minutes)	17	22
09240	IV Sedation (per ½ hour)	111	179
09310	Consult (No Add'l Procs Indicated)	45	49
09910	Appl Of Desensitizing Med	28	28
09940	Occlusal Guards by Report	162	269
09951	Occlusal Adjustment – Limited	37	57
09952	Occlusal Adjustment-Complete	148	244
09980	Sterilization Surcharge (per visit)	5	5
09990	After Hours Surcharge	25	25
09999	Broken Appointment Fee – Per ½ Hour	15	15
Orthodontics – Per Case			
08070	Orthodontic – Fully Banded 2 Yr. Case - Transitional	NB	2375
08080	Orthodontic – Fully Banded 2 Yr. Case - Adolescent	NB	2375

Limitations to dental services:

- *Full mouth X-rays and panoramic X-rays are covered once every thirty-six (36) months, except when taken for diagnosis of third molars, cysts, or neoplasms*
- *Full mouth debridement (ADA Code 4355) is limited to once every thirty-six (36) months*
- *Perio Maintenance After Active Therapy (ADA Code 04910) is limited to twice within twelve (12) months after Osseous Surgery*
- *Denture relines for complete or partial conventional dentures are included in the denture fee for the six (6) month period following insertion. Thereafter relines are covered once every twelve (12) months.*
- *Sealants (ADA Code 01351) are limited to the first and second permanent molars. Additionally, coverage is limited to members under age 16.*
- *Root canal retreatment within one (1) year following the initial therapy is the responsibility of the original treating Participating Dental Provider (ADA Codes 3346, 3347, 3348)*
- *Orthodontics coverage is limited to treatment for a handicapping malocclusion, which is defined as an occlusion causing difficulty in chewing, speech or overall dental functioning. Coverage is limited to two (2) years of active treatment per eligible member per lifetime. Patients must be banded by age 19. If Dental Plan pays for interceptive therapy, minor tooth movement or other orthodontic treatment prior to fully banded care, the Dental Plan payment for inceptive therapy, minor tooth movement or other orthodontic treatment will be deducted from dental Plan's payment for fully banded care.*

- *Root planing or scaling (ADA Code 4341) is covered once every six (6) months per quadrant.*
- *Periodontal surgery of any type, including gingivectomy, gingivoplasty, gingival curettage, gingival flap procedure, mucogingival surgery, osseous surgery, pedicle graft, or free tissue graft is covered once every thirty-six (36) months per quadrant.*
- *Osseous grafts are covered once every thirty-six (36) months per quadrant or surgical site.*
- *Replacement of crowns, bridges and fixed or removable prosthetic appliances inserted prior to Dental Plan coverage is not covered until twelve (12) months of continuous Dental Plan coverage have been achieved. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this twelve- (12) month period, the plan will cover only the procedures associated with the addition.*

Not covered:

- *Services of dentists or other practitioners of healing arts not associated with Kaiser Permanente and DBP except upon referral arranged by a Participating Dental Provider and authorized by us, or when required in a covered emergency. Such excluded services mean any kind of dental care and anything prescribed in connection therewith.*
- *Hospitalization for any dental procedure, except as may otherwise be covered by the Plan*
- *Any cosmetic, beautifying, or elective procedure*
- *Any procedure not performed in a dental office setting*
- *Experimental procedures, implantations, or pharmacological regiments*
- *Services for injuries or conditions which are covered under Workers' Compensation or Employer's Liability laws; services which are provided without cost to the Member by any municipality, county, or other political subdivision. This exclusion does not apply to any services that are covered by Medicaid.*
- *Replacement of denture, bridgework, and/or dental appliances previously supplied under this benefit, due to loss or theft, or for any reason within sixty (60) months of initial insertion*
- *Services which, in the opinion of the attending Participating Dental Provider, are not necessary for the member's dental health*
- *Dental services pertaining, or related, to the Temporomandibular Joint (TMJ), except when those services are included on the attached dental fee schedule and are performed by the member's Participating Dental Provider in that provider's office*
- *Charges for failure to keep a scheduled dental appointment. The charges are listed in the attached dental fee schedule, and are charged by the general dentist and/or specialist, for each missed ½ hour appointment without twenty-four (24) hours notice.*
- *Services of Pedodontists and/or Prosthodontists*
- *Charges for second opinions, unless previously authorized by the Plan*
- *Occlusal guards are excluded for any purpose other than habitual grinding*
- *Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction*
- *Procedures relating to the change and maintenance of vertical dimension or the restoration of occlusion*
- *Dental lab fees for excisions and biopsies. Procedures requiring lab fees are shown with asterisks ("**").*
- *Drugs obtainable with or without a prescription (see your prescription drug benefit as described in Section 5(f) for coverage of dental prescriptions)*
- *The setting of fractures or dislocations (see your medical and surgical benefits as described in Sections 5(a) and 5(b) for coverage of these services)*
- *Treatment of malignancies, cysts or neoplasm or congenital malformations. (see your medical and surgical benefits as described in Sections 5(a) and 5(b) for coverage of these services)*

- *Dental expenses incurred in connection with any dental procedure started prior to member's eligibility with Dental Plan. Examples: orthodontic work in progress, teeth prepared for crowns, root canal therapy in progress.*
- *Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure, in accordance with the "Standards of Care" established by DBP for its participating providers.*
- *Placement of dental implants, implant-supported abutments and prostheses.*
- *Billing for incision and drainage (ADA Code 7510) is excluded if the involved abscessed tooth is removed on the same date of service.*
- *Placement of fixed bridgework solely for the purpose of achieving periodontal stability.*
- *Procedures not shown on the dental service and fees listing*

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.

Medicare Prepaid Plan Enrollment

We offer Medicare recipients the opportunity to enroll in our Plan through Medicare. Annuitants and former spouses with FEHB coverage and Medicare Parts A and B or Part B only may elect to either drop their FEHB coverage and enroll in a Medicare prepaid plan or remain enrolled in the FEHB Program and simultaneously enroll in the Medicare prepaid plan when one is available in their area. If you choose to disenroll from the FEHB Program you may then later re-enroll in the FEHB Program.

Most federal annuitants have Medicare Part A (hospital coverage). Those without Medicare Part A may join this Medicare prepaid plan after they have elected to purchase Medicare Part A in addition to continuing to pay for their Part B premium. Before you drop your FEHB coverage and apply for coverage in the Medicare prepaid plan, please contact us at 301/816-5690 or 301/816-6143.

Expanded Dental Benefits

We are pleased to offer you an additional choice of dental coverage to supplement what is currently available to you through the FEHB program. This dental program is designed to enhance the level of dental benefits that you currently receive. Your basic discounted dental coverage through the Plan is not affected by this enhanced product offering. This supplemental coverage is through Delta Dental, a national dental provider, and is only available to members of Kaiser Permanente.

Delta Premier, a table of allowances program, allows you to choose any licensed dentist; however, discounted pricing is available only through Delta's provider network. After you satisfy a deductible, Delta will pay a predetermined amount toward each covered service. You will not need to satisfy a deductible toward covered preventive services you receive. Delta Premier offers a full range of covered services: diagnostic, preventive, restorative, endodontics, periodontics, oral surgery, and both fixed and removable prosthodontics. Orthodontic coverage is not available. Covered services will be phased in over a three (3) year period.

Delta Premier is only available to you if you are enrolled in Kaiser Permanente's Plan for the FEHB. You do not need to purchase this program to receive the basic dental coverage included in the Plan. Premium payments should be made directly to Delta Dental. Payroll deduction is not available for this program.

How to Enroll: An enrollment form for Delta Premier is included in your Kaiser Permanente enrollment kit. If you would wish more information on Delta Premier, please call Delta Dental at 800/932-0783.

Monthly Premiums:	
Self	$18.45
Self and One Party	$33.45
Family	$52.45

Section 6. General exclusions -- things we don't cover

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

You will only need to file a claim when you receive emergency services from non-plan providers. 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 301/468-6000 inside the Washington, DC metropolitan area or at 800/777-7902 outside the Washington, DC metropolitan area. Our TTY telephone number is 301/879-6380.

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

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

Submit your claims to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Claims Department
P. O. Box 6233
Rockville, Maryland 20849-6233

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

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: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 East Jefferson Street, Rockville, MD 20852, Attn: Member Services Appeals Unit; 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 Monday through Friday at 301/468-6000 inside the Washington, DC metropolitan area or 800/777-7902 outside the Washington, DC metropolitan area. Our TTY is 301/879-6380. Weekends and holidays, please call 703/359-7878 inside the Washington, DC metropolitan area or 800/777-7904 outside the Washington, DC metropolitan area. Our weekend TDD numbers are 703/359-7616 or toll free at 800/700-4901. 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. 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, please call 301/468-6000 or 800/777-7902 or TTY 301/879-6380.

(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 another plan -- a Medicare managed care plan. This is a health care choice (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 Kaiser Permanente Medicare Plus (an 1876 Medicare Cost plan), and also remain enrolled in our FEHB Plan. To be eligible for Kaiser Permanente Medicare Plus, you must have Medicare Parts A and B or Medicare Part B only.

You may enroll in Medicare Plus at no additional monthly premium cost to you. This plan offers you enhanced benefits and additional flexibility in how you receive your medical care. If you enroll in Medicare Plus, you still receive all of your in-network care through Kaiser Permanente contracted Plan Providers. When you use Plan Providers, some of your copayments and coinsurance will be lowered.

Under the Kaiser Permanente Medicare Plus plan, you may also choose to receive care from providers outside our network. If you receive medical care from Medicare participating providers outside our network, Medicare will pay its share of approved charges. You will be responsible for the Medicare coinsurance and deductible amounts.

Under Kaiser Permanente Medicare Plus, when you receive your medical care through Plan Providers, the following copayments or coinsurance have been lowered:

- **Physician Office Visits (preventive and non-preventive):** $5
- **Dialysis:** $0
- **Voluntary sterilizations and family planning:** $5
- **Rehabilitative and Other Therapies:** $5; unlimited number of visits as medically necessary
- **Cardiac Rehabilitation:** $5
- **Comprehensive Outpatient Rehabilitation Facility Services:** $5
- **Chiropractic Services and Acupuncture beyond what is covered by Medicare:** $5 up to 20 visits per modality per calendar year
- **Urgent Care Services:** $5
- **Outpatient Substance Abuse Rehabilitation:** $5
- **Outpatient Mental Health Services:** $5
- **Vision Services:** $5 for eye examinations and refractions; covered up to the Medicare-allowable amount for glasses after cataract surgery; 25% discount on eyeglass lenses and frames; 15% discount on initial purchase of contact lenses
- **Hearing exams:** $5 for routine and Medicare-covered hearing tests
- **Podiatry (medically necessary):** $5
- **Blood transfusions:** $5

- **Blood and blood components:** $0 if the blood is replaced; otherwise you must replace the first three (3) pints or pay non-replacement fees for whole blood; $0 for all blood products, except for hemophiliac factors that are covered under the Prescription Drug benefit
- **Health Education Classes:** $10-$20 for health education classes

If you would like information about Kaiser Permanente Medicare Plus, please call 301/468-6000 or 800/777-7902 or TTY 301/879-6380.

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

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care service area.

· **If you do 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.

Copayment

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

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.

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 serving a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services

A service, supply, item or drug that:
(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 available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or
(4) is subject to the approval or review of an Institutional Review Board; or
(5) requires an informed consent that describes the service as experimental or investigational.

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.

Your Primary care copayment

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

Your 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 the Mid-Atlantic States, Inc.

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 the Mid-Atlantic States, Inc. – 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 visit to your primary care provider $20 per visit to a specialist	16
Services provided by a hospital:		
• Inpatient.....	$100 per admission	32
• Outpatient.....	$ 50 per outpatient surgery	33
Emergency benefits:		
• In-area	$50 per visit	37
• Out-of-area	$50 per visit	37
Mental health and substance abuse treatment:	Regular cost sharing	38
Prescription drugs.....	$10 per prescription or refill for generic drugs or $20 per prescription or refill for brand-name drugs if you get your prescription filled at a Plan medical center pharmacy $8 per prescription or refill for generic drugs or $18 per prescription or refill for brand-name drugs if you get your prescription filled through our mail order delivery system $20 per prescription or refill for generic drugs or $40 per prescription or refill for brand-name drugs if you get your prescription filled at an affiliated network pharmacy	41
Dental Care.....	Various copayments based on procedure rendered	48
Vision Care.....	Refractions; $10 per office visit	22

Special features: Flexible benefits option; 24 hour nurse line; Services for deaf and hearing impaired; Centers of Excellence; Travel benefit; Services from other Kaiser Permanente Plans.		45
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum).....	Nothing after $1,500/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	14

Notes

2003 Rate Information for
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

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	E31	$92.42	$30.81	$200.25	$66.75	$109.37	$13.86
Self and Family	E32	$219.97	$73.32	$476.60	$158.86	$260.29	$33.00