

# Kaiser Foundation Health Plan of Georgia, Inc.

<http://www.kp.org/ga>.



KAISER PERMANENTE®

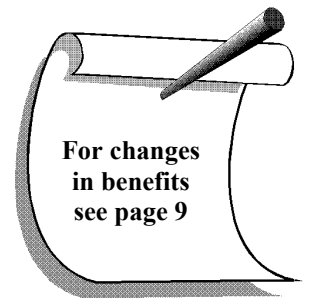
## 2003

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### A Health Maintenance Organization

**Serving:** *Atlanta, Georgia metropolitan area*

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



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

#### **Enrollment codes for this Plan:**

**F81 Self Only**  
**F82 Self and Family**

Authorized for distribution by the:



UNITED STATES  
OFFICE OF PERSONNEL MANAGEMENT  
RETIREMENT AND INSURANCE SERVICE  
[HTTP://WWW.OPM.GOV/INSURE](http://www.opm.gov/insure)



RI 73-321



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](http://www.opm.gov/insure).

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

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](http://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.

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## Introduction

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This brochure describes the benefits of Kaiser Foundation Health Plan of Georgia, Inc. under our contract (CS 2163) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Kaiser Foundation Health Plan of Georgia, Inc.'s administrative office is:

Kaiser Foundation Health Plan of Georgia, Inc.  
Nine Piedmont Center  
3495 Piedmont Road, NE  
Atlanta, Georgia 30305-1736

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.

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## Plain Language

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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 Georgia, 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 the structure of this brochure, let us know. Visit OPM's "Rate Us" feedback area at [www.opm.gov/insure](http://www.opm.gov/insure) or e-mail us at [fehwebcomments@opm.gov](mailto:fehwebcomments@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.

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## Stop Health Care Fraud!

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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.



- 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 404/261-2590 and explain the situation.
  - If we do not resolve the issue:

**CALL – THE HEALTH CARE FRAUD HOTLINE**

**202/418-3300**

**OR WRITE TO:**

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

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

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## Section 1. Facts about this HMO plan

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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-child 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 or coinsurance described in this brochure. When you receive covered services from non-Plan providers, such as emergency services or services under our travel benefit, you may have to submit claim forms.

**You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.**

### How we pay providers

We contract with the Southeast Permanente Medical Group, Inc. and hospitals to provide the benefits in this brochure. Your medical group physicians are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee-for-service, and incentive payments. Other Plan providers accept a negotiated payment from us. You will only be responsible for your copayments or coinsurance. If you would like further information about the way Kaiser Permanente physicians are paid to provide or arrange medical and hospital care for you, please call us at 404/261-2590.

### 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](http://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 Georgia, Inc., a Georgia non-profit corporation, is a wholly owned subsidiary of Kaiser Foundation Health Plan, Inc. We are a federally qualified health maintenance organization. This Plan is part of the Kaiser Permanente Medical Care Program, a group of non-profit organizations and contracting medical groups that serve over 8 million members nationwide.
- In October 1985, Kaiser Permanente began operations in the State of Georgia. Kaiser Permanente is one of the largest group practice health plans in Georgia. We provide health care to more than 281,000 members in the greater Atlanta area.
- In 2000, we received a three-year, full accreditation now known as "Excellent Accreditation" from the National Committee for Quality Assurance (NCQA).
- All Kaiser Permanente affiliated hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the commission that sets nationally recognized health care standards for hospitals and other health care organizations.
- Kaiser Permanente reviews the credentials – including licensing, education, training, experience, health status, judgement, and office conditions – of physicians before they are selected to participate in our medical care program, and we review them on an ongoing basis.
- We credential Plan providers in accord with national standards.

- Plan physicians are members of American Specialty Boards or are Board eligible.

If you want more information about us, call 404/261-2590, or write to: Kaiser Permanente, Member Services Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736.

You may also contact us by visiting our website at [www.kp.org/ga](http://www.kp.org/ga).

### **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 includes these counties:

Bartow, Barrow, Butts, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale, Spalding, and Walton.

**NOTE:** Here are some things to keep in mind.

If you are currently enrolled in, or plan to enroll in, our Senior Advantage plan, the service area requirements may be different from the service area shown above for other federal members.

To enroll in the Senior Advantage plan you must live in the following counties: Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, and these zip codes in Paulding county – 20134, 30127, and 30141.

If you lose eligibility for the Kaiser Permanente Senior Advantage plan because you move outside the Senior Advantage service area, you will no longer be entitled to the enhanced benefits under Section 9 of this brochure.

Ordinarily, you must get your care from 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 48; and for emergency care obtained from any non-Plan provider, as described on page 38. 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.

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## Section 2. How we change for 2003

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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 9.0% for Self Only or 9.0% for Self and Family.
- We decreased the copayment for eye refractions for eyeglasses from \$15 per visit to \$10 per visit.
- Eye refractions for eyeglasses are no longer limited to one per year.
- We changed the time for notification of an emergency admission to a non-Plan facility within our service area from 48 hours to 24 hours.
- We reduced the copayment for each mental health and substance abuse group therapy visit from \$10 to \$5 per visit.
- We increased your prescription drug copayments from \$5 per prescription to \$10 per prescription for prescriptions or refills obtained at a Plan medical office pharmacy, and from \$11 per prescription to \$16 per prescription for prescriptions or refills obtained at a Plan participating community pharmacy.

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## Section 3. How you get care

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### Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call our Member Services Department at 404/261-2590 (locally), 800/611-1811 (long distance), or 800/255-0056 (TTY number), or write to us at: Kaiser Foundation Health Plan of Georgia, Inc., Member Services Department, Nine Piedmont Center, 3495 Piedmont Rd., NE, Atlanta, GA 30305-1736.

### Where you get covered care

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

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We contract with the Southeast Permanente Medical Group, Inc. (Plan physicians), an independent multi-specialty group of physicians to provide or arrange all necessary physician care. Plan physicians, nurse practitioners, physician assistants, and other skilled medical personnel working as medical teams provide your health care services. Specialists consult with these medical teams in determining your treatment. Plan physicians refer patients to community specialists when necessary.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website at [www.kp.org/ga](http://www.kp.org/ga).

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. Other services, such as physical therapy, laboratory, and X-ray, are available at Plan facilities and other designated locations. Hospital care is provided at local community hospitals. We list these in the provider directory, which we update periodically. The list is also on our website.

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

### What you must do to get covered care

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

- **Primary care**

We require you to choose a primary care physician when you enroll. Every member of your family should have his or her own primary care physician. If you do not select a primary care physician upon enrollment, we will assist you by identifying a physician in a medical center near your home and including you in that physician's panel of patients. That physician will be listed in our records as your primary care physician until you make a selection and inform us of your decision.

When choosing your primary care physician, keep in mind that your choice will determine where you will receive specialty care. Your primary care physician has an established relationship with a specific group of specialty care physicians with whom he or she works and trusts. By referring only to a select group of specialists, your primary care physician is better able to ensure that you receive high-quality care.

You may select your primary care physician from the medical group physicians or from a group of participating doctors – commonly referred to as Affiliated Community Physicians – practicing in their own offices all over town. The medical group physicians provide care at Kaiser Permanente medical centers in our service area. An affiliated community physician provides care in his or her own medical office. Your primary care physician can be a family practitioner, internist, or pediatrician. Adults should select an internal medicine or family practice physician. Parents can choose a pediatric or family practice physician for their children, or a family practice physician can be selected for the entire family. To learn how to choose or change a primary care physician, please call our Member Services Department at 404/261-2590 (locally), 800/ 611-1811 (long distance), or 800/255-0056 (TTY number).

If you wish to be treated by a physician at a Kaiser Permanente medical center or by another affiliated community physician, you will need to select that individual as your new primary care physician before scheduling treatment.

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. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

- **Specialty care**

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

Here are other things you should know about specialty care:

- Keep in mind that your primary care physician choice determines which specialists are available to you. Your primary care physician has an established relationship with a specific group of specialty care doctors. By referring only to a certain group of specialists, your primary care physician is better able to ensure that you receive quality care.

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or
  - reduce our service area and you enroll in another FEHB plan,
 you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

• **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Member Services Department immediately at 404/261-2590. 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 92<sup>nd</sup> 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.

### **Service 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 preauthorization. Your physician must obtain preauthorization for the following services:

- All inpatient hospital care services
- Extended care/skilled nursing facility services
- Inpatient mental health or substance abuse services
- Inpatient rehabilitation therapy services or programs
- Organ and tissue transplants
- Bariatric surgery
- Infertility procedures
- Outpatient procedures and services:
  - Dialysis
  - Human Growth Hormone
  - Carpal tunnel surgery
  - Repair of nasal septum
  - Speech therapy
  - Comprehensive outpatient rehabilitation facility services
  - Home Health Care
  - Hospice care
  - Durable medical equipment
  - Orthopedic and prosthetic devices
  - Circumcision (pediatric and adult)
  - Plastic or reconstructive surgery
  - Varicose vein stripping
  - Blepharoplasty
  - Spinal cord stimulation
  - HBO treatment
  - Biofeedback or other pain management treatment
  - Intrathecal and epidural infusion pumps
- Any request for non-Plan provider



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## Section 4. Your costs for covered services

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

- **Copayments** A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.  
Example: When you see your primary care physician you pay a copayment of \$10 per visit.
- **Deductible** We do not have a deductible.
- **Coinsurance** Coinsurance is the percentage of our allowance that you must pay for certain services you receive.  
Example: In our Plan, you pay 50% of our allowance for infertility services and 20% of our allowance for durable medical equipment.
- **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 \$20 charge for each bill sent for unpaid services.

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

After your copayments and coinsurance total \$2,000 per person or \$5,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services as described in this brochure:

- prescription drugs
- durable medical equipment
- external prosthetic and orthotic devices
- the \$25 charge for follow-up or continuing care outside the service area
- chiropractic services
- dental 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.

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## Section 5. Benefits -- OVERVIEW

*(See page 9 for how our benefits changed this year and page 71 for a benefits summary.)*

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**NOTE:** This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 404/261-2590 or at our website at [www.kp.org/ga](http://www.kp.org/ga).

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

<b>I M P O R T A N T</b>	<p><b>Here are some important things to keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Plan physicians must provide or arrange your care.</li> <li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li> <li>• We have no calendar year deductible.</li> <li>• <b>YOU MUST GET PREAUTHORIZATION FOR SOME MEDICAL PROCEDURES.</b> Please refer to the preauthorization shown in Section 3 to be sure which services and supplies require preauthorization.</li> <li>• Note: Instead of a \$10 charge, you pay only \$5 if you enroll in our Medicare+Choice Plan and assign your Medicare benefits to the Plan.</li> </ul>	<b>I M P O R T A N T</b>
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Benefit Description	You pay
<b>Diagnostic and treatment services</b>	
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> <li>• In a physician's office</li> <li>• Initial examination of a newborn child covered under a family enrollment</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> </ul>	\$10 per office visit
<ul style="list-style-type: none"> <li>• In a Plan After-Hours Care Center or any other urgent care center designated by the Plan</li> </ul>	\$20 per visit
<ul style="list-style-type: none"> <li>• In a skilled nursing facility</li> <li>• During a hospital stay</li> <li>• At home</li> </ul>	Nothing

<b>Lab, X-ray, and other diagnostic tests</b>	<b>You pay</b>
<p>Tests, such as:</p> <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• CAT Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	Nothing
<b>Preventive care, adult</b>	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>• Total blood cholesterol</li> <li>• Colorectal cancer screening, including <ul style="list-style-type: none"> <li>—Fecal occult blood test</li> <li>—Sigmoidoscopy - every five years starting at age 50</li> </ul> </li> <li>• Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older</li> <li>• Routine pap test</li> </ul> <p>Note: You should consult with your physician to determine what is appropriate for you.</p> <p>Note: You pay only one copayment if you receive your routine screening on the same day as your office visit.</p>	\$10 per office visit
<ul style="list-style-type: none"> <li>• Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>—From age 35 through 39, one during this five year period</li> <li>—From age 40 through 64, one every calendar year</li> <li>—At age 65 and older, one every two consecutive calendar years</li> </ul> </li> </ul> <p>Note: In addition to routine screening, we cover mammograms when medically necessary to diagnose or treat your illness.</p> <p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza/Pneumococcal vaccines, annually, age 65 and over</li> </ul>	Nothing

*Preventive care, adult – continued on next page*

Preventive care, adult <i>(continued)</i>	You Pay
<p><i>Not covered:</i></p> <p><i>Physical exams required for:</i></p> <ul style="list-style-type: none"> <li>• <i>Obtaining or continuing employment</i></li> <li>• <i>Participating in employee programs</i></li> <li>• <i>Insurance or licensing</i></li> <li>• <i>Court order required for parole or probation</i></li> <li>• <i>Attending schools</i></li> <li>• <i>Travel</i></li> </ul>	<p><i>All charges</i></p>
Preventive care, children	You pay
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> <li>• Well-child preventive care visits (up to 2 years of age)</li> </ul>	<p>Nothing</p>
<ul style="list-style-type: none"> <li>• Services, such as: <ul style="list-style-type: none"> <li>—Eye screenings to determine the need for vision correction</li> <li>—Hearing screenings to determine the need for hearing correction</li> </ul> </li> <li>• Examinations done on the day of immunizations</li> <li>• Well-child care charges for routine examinations, and care (age 2 and over)</li> </ul>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <p><i>Physical exams required for:</i></p> <ul style="list-style-type: none"> <li>• <i>Obtaining or continuing employment</i></li> <li>• <i>Participating in employee programs</i></li> <li>• <i>Insurance or licensing</i></li> <li>• <i>Court order required for parole or probation</i></li> <li>• <i>Attending schools or camp</i></li> <li>• <i>Travel</i></li> </ul>	<p><i>All charges</i></p>

<b>Maternity care</b>	<b>You Pay</b>
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your Plan physician will extend your inpatient stay if medically necessary.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c) for hospital benefits and Section 5(b) for surgery benefits.</li> </ul>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Routine sonograms to determine fetal age, size, or sex</i></li> </ul>	<i>All charges</i>
<b>Family planning</b>	<b>You pay</b>
<p>Family planning services, including:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5 (b))</li> <li>• Information on birth control</li> </ul> <p>Note: We cover surgically implanted contraceptives, diaphragms, injectable contraceptive drugs, intrauterine devices (IUDs), and diaphragms under your prescription drug benefit.</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> <li>• <i>Genetic counseling</i></li> </ul>	<i>All charges</i>

Infertility services	You Pay
<p>Diagnosis and treatment of involuntary infertility</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>—intravaginal insemination (IVI)</li> <li>—intracervical insemination (ICI)</li> <li>—intrauterine insemination (IUI)</li> </ul> </li> <li>• Fertility drugs</li> </ul> <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefits.</p>	50% of our allowance
<p><i>Not covered:</i></p> <p><i>These exclusions apply to fertile as well as infertile individuals or couples:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>—<i>in vitro fertilization</i></li> <li>—<i>embryo transfer and gamete intrafallopian transfer (GIFT)</i></li> </ul> </li> <li>• <i>Services and supplies related to excluded ART procedures</i></li> <li>• <i>Semen or eggs, and services and supplies related to their procurement and storage</i></li> </ul> <p><i>Note: Infertility services are not available when either member of the family has been voluntarily surgically sterilized.</i></p>	<i>All charges</i>
Allergy care	You pay
Testing and treatment	\$10 per office visit
Allergy injections	\$5 per office visit
Allergy serum	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Provocative food testing</i></li> <li>• <i>Sublingual allergy desensitization</i></li> </ul>	<i>All charges</i>

Treatment therapies	You Pay
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: We limit high dose chemotherapy in association with autologous bone marrow transplants to those transplants listed under Section 5(b), Organ/tissue transplants.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> </ul> <p>Note: We cover growth hormone therapy (GHT) under the prescription drug benefit.</p> <ul style="list-style-type: none"> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> </ul> <p>Note: We waive office visit charges if you enroll in Medicare Part B and assign your Medicare benefits to us.</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered</i></li> </ul>	<p><i>All charges</i></p>



Physical and occupational therapies	You pay
<p>Two consecutive months of therapy per condition:</p> <ul style="list-style-type: none"> <li>• Physical therapy by qualified physical therapists to restore bodily function when you have a total or partial loss of bodily function due to illness or injury</li> <li>• Occupational therapy by occupational therapists to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life</li> </ul> <p>Note: If you have not received 20 or more outpatient visits within the two-month period that started with your first visit to a therapist, we may continue your therapy for up to 20 outpatient visits per therapy per condition.</p> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction is provided for up to 12 weeks or 36 visits</li> <li>• Comprehensive outpatient rehabilitation facility services are provided up to two months per condition. Outpatient rehabilitation, including diagnostic and restorative services, providing a program of physical, speech, occupational, respiratory therapy, social and psychological services, and other items and services that are medically necessary for rehabilitation. The two month limit applies to all inpatient and outpatient comprehensive rehabilitation services you may receive for the same condition.</li> </ul>	<p>\$10 per outpatient visit</p> <p>Nothing for inpatient</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Long-term physical therapy or occupational therapy</i></li> <li>• <i>Exercise programs</i></li> <li>• <i>Cognitive rehabilitation programs</i></li> <li>• <i>Vocational rehabilitation programs</i></li> <li>• <i>Therapies done primarily for education purposes</i></li> </ul>	<p><i>All charges</i></p>

<b>Speech therapy</b>	<b>You Pay</b>
<p>Two consecutive months of therapy per condition:</p> <ul style="list-style-type: none"> <li>• Speech therapy by speech therapists when medically necessary</li> </ul> <p>Note: If you have not received 20 or more outpatient visits within the two-month period that started with your first visit to a therapist, we may continue your therapy for up to 20 outpatient visits per therapy per condition.</p>	<p>\$10 per outpatient visit</p> <p>Nothing for inpatient</p>
<p><i>Not covered:</i></p> <p><i>Speech therapy that is not medically necessary such as:</i></p> <ul style="list-style-type: none"> <li>• <i>Therapy for educational placement or other educational purposes</i></li> <li>• <i>Training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation</i></li> <li>• <i>Therapy for tongue thrust in the absence of swallowing problems</i></li> <li>• <i>Voice therapy for occupation or performing arts</i></li> </ul>	<p><i>All charges</i></p>
<b>Hearing services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• Hearing test to determine the need for hearing correction</li> <li>• Hearing testing for children through age 17 (see Preventive care, children)</li> </ul>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>All other hearing tests</i></li> <li>• <i>Hearing aids, tests to determine their effectiveness, and examinations for them</i></li> </ul>	<p><i>All charges</i></p>
<b>Vision services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• Eye refractions for eyeglasses (to provide written lens prescription)</li> </ul>	<p>\$10 per office visit</p>
<ul style="list-style-type: none"> <li>• Diagnosis and treatment of diseases of the eye</li> </ul>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Corrective eyeglasses and frames or contact lenses (including the examination and fitting of contact lenses)</i></li> <li>• <i>Refractions for contact lenses</i></li> <li>• <i>Eye exercises and orthoptics</i></li> <li>• <i>Radial keratotomy and other refractive surgery</i></li> <li>• <i>Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia), and astigmatism</i></li> </ul>	<p><i>All charges</i></p>

Foot care	You Pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></li> <li>• <i>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)</i></li> </ul>	<p><i>All charges</i></p>

Orthopedic and prosthetic devices	You Pay
<p>External prosthetic and orthotic devices, such as:</p> <ul style="list-style-type: none"> <li>• Ostomy and urological supplies</li> <li>• Artificial limbs and eyes; stump hose</li> <li>• Braces</li> <li>• Therapeutic shoes required for conditions associated with diabetes</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</li> <li>• Scoliosis braces</li> <li>• Lenses following cataract removal</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</li> </ul>	20% of our allowance
<ul style="list-style-type: none"> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, intraocular lens following cataract removal, cochlear implants, and surgically implanted breast implant following mastectomy.</li> </ul> <p>Note: See Section 5(b) for coverage of the surgery to insert the device.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Foot orthotics</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li>• <i>Devices, equipment, supplies, and prosthetics related to the treatment of sexual dysfunction</i></li> <li>• <i>External and internally implanted hearing aids</i></li> <li>• <i>Experimental or research equipment</i></li> </ul>	<i>All charges</i>

<b>Durable medical equipment (DME)</b>	<b>You pay</b>
<p>Covered DME items include:</p> <ul style="list-style-type: none"> <li>• Hospital beds</li> <li>• Wheelchairs, except motorized</li> <li>• Crutches</li> <li>• Walkers</li> <li>• Infant apnea monitors</li> <li>• Oxygen-dispensing equipment</li> <li>• Oxygen</li> </ul> <p>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.</p>	<p>20% of our allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Motorized wheel chairs</i></li> <li>• <i>Comfort, convenience, or luxury equipment or features</i></li> <li>• <i>Exercise or hygiene equipment</i></li> <li>• <i>Non-medical items such as sauna baths or elevators</i></li> <li>• <i>Modifications to your home or car</i></li> <li>• <i>Devices for testing blood or other body substances</i></li> <li>• <i>Electronic monitors of bodily functions, except apnea monitors and blood glucose monitors</i></li> <li>• <i>Disposable supplies</i></li> <li>• <i>Replacement of lost equipment</i></li> <li>• <i>Repair, adjustments, or replacements necessitated by misuse</i></li> <li>• <i>More than one piece of durable medical equipment serving essentially the same function, except for replacements other than those necessitated by misuse or loss</i></li> <li>• <i>Spare or alternate use equipment</i></li> <li>• <i>Devices, equipment, supplies, and prosthetics for the treatment of sexual dysfunction disorders</i></li> <li>• <i>External and internally implanted hearing aids</i></li> <li>• <i>Experimental or research equipment</i></li> </ul>	<p><i>All charges</i></p>

Home health services	You pay
<p>If you are homebound and reside in the service area:</p> <ul style="list-style-type: none"> <li>• You may receive home health services of nurses and health aides, physical or occupational therapists, and speech and language pathologists</li> <li>• Services include oxygen therapy, intravenous therapy, and medications</li> </ul> <p>Note: Your Plan physician will periodically review the program for continuing appropriateness and need.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i></li> <li>• <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i></li> <li>• <i>Custodial care</i></li> <li>• <i>Care that the Medical Director of the Medical Group or his/her designee determines may be appropriately provided in a Plan facility, skilled nursing facility, or other facility we designate and we provide or offer to provide that care in one of these facilities</i></li> <li>• <i>Services outside our service area</i></li> </ul>	<i>All charges</i>

<b>Chiropractic</b>	<b>You Pay</b>
<p>Chiropractic services up to 30 visits per calendar year, for the following services:</p> <ul style="list-style-type: none"> <li>• Evaluation and management of musculoskeletal disorders</li> <li>• Routine chiropractic X-rays provided in the chiropractor’s office (not to exceed 4 views)</li> <li>• Chiropractic adjustments</li> <li>• Appropriate therapies (e.g., hot and cold packs) not to exceed 2 per visit</li> </ul> <p>Note: You may see a chiropractor without referral from your Plan physician. Services must be provided from our list of Participating Chiropractors. Please contact us to get the list.</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Vitamins and supplements</i></li> <li>• <i>Vax-D</i></li> <li>• <i>Structural supports</i></li> <li>• <i>Massage therapies</i></li> <li>• <i>Maintenance/preventative care</i></li> <li>• <i>Acupuncture therapy</i></li> <li>• <i>Physical, speech, and occupational therapy provided by a chiropractor</i></li> <li>• <i>Neurological testing, unless authorized by your primary care physician</i></li> <li>• <i>Laboratory and pathology services, unless authorized by your primary care physician</i></li> </ul>	<p><i>All charges</i></p>
<b>Alternative treatments</b>	
<p>No benefit</p>	<p><i>All charges</i></p>

Educational classes and programs	You Pay
Training in self-care and preventive care	\$10 per office visit
Health education publications and education about how to use our services and supplies	Nothing
General health education not addressed to a specific condition, as well as Lamaze classes and weight control classes	Charges vary (\$0 to \$50)
<p>Quit Smoking Cessation Program</p> <p>This program includes six sessions with one follow up session, lectures, a quit smoking kit, discussions and relaxation techniques, a patented realistic cigarette substitute, and vouchers for nicotine patches</p>	\$20
Any member who is enrolled and attends the smoking cessation program is eligible to receive nicotine patches (with voucher) at a Plan pharmacy	\$5
<p>Quit Smoking - Self-Help Program: No Nag, Do it Myself</p> <p>This program meets once and you will design a quitting plan, receive information about nicotine and why it's so hard to quit smoking, and a Do-it-Your-Own-Way guide to quitting smoking</p>	\$5
<p>Note: This information is a summary of services available. Please call us at 404/261-2590 for availability and location of these classes.</p>	



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

<b>I M P O R T A N T</b>	<p><b>Here are some important things to keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Plan physicians must provide or arrange your care.</li> <li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li> <li>• We do not have a calendar year deductible.</li> <li>• <b>YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES.</b> Please refer to the preauthorization shown in Section 3 to be sure which services and surgeries require preauthorization.</li> <li>• 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.).</li> </ul>	<b>I M P O R T A N T</b>
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Benefit Description	You pay
<b>Surgical procedures</b>	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Pre-surgical testing</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see reconstructive surgery)</li> <li>• 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</li> <li>• Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices for coverage information</li> </ul>	<p>\$10 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>

*Surgical procedures—continued on next page*

<b>Surgical procedures</b> <i>(continued)</i>	<b>You Pay</b>
<ul style="list-style-type: none"> <li>• Voluntary sterilization (e.g., Tubal ligation, Vasectomy)</li> <li>• Surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs). Note: Drugs and devices are covered under Section 5(f)</li> <li>• Other implanted time-release drugs</li> <li>• Treatment of burns</li> </ul>	<p>\$10 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine foot care; see Foot care</i></li> </ul>	<p><i>All charges</i></p>
<b>Reconstructive surgery</b>	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>—the condition produced a major effect on the member’s appearance; and</li> <li>—the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities, cleft lip, cleft palate, birthmarks, web fingers, and toes.</li> <li>• Treatment of port wine stains on the face of members 18 years or younger</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>—surgery to produce a symmetrical appearance on the other breast;</li> <li>—treatment of any physical complications, such as lymphedemas; and</li> <li>—breast prostheses and surgical bras and replacements (see Prosthetic devices)</li> </ul> </li> </ul> <p>Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$10 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>

*Reconstructive surgery – continued on next page*

<b>Reconstructive surgery</b> <i>(continued)</i>	<b>You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to change physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<p><i>All charges</i></p>
<b>Oral and maxillofacial surgery</b>	<b>You pay</b>
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones</li> <li>• Surgical correction of cleft lip, cleft palate, or severe functional malocclusion</li> <li>• Removal of stones from salivary ducts</li> <li>• Excision of leukoplakia or malignancies</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures</li> </ul>	<p>\$10 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> <li>• <i>Shortening of the mandible or maxillae for cosmetic purposes and correction of malocclusion</i></li> </ul>	<p><i>All charges</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single –Double</li> <li>• Pancreas</li> <li>• Allogeneic (donor) bone marrow</li> <li>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> </ul> <p>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</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover your transplant.</p>	<p>\$10 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Implants of non-human or artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> </ul>	<p><i>All charges</i></p>
Anesthesia	
<p>Professional services provided in:</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	<p>Nothing</p>

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

<b>I M P O R T A N T</b>	<p><b>Here are some important things to remember about these benefits:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.</li> <li>• We do not have a calendar year deductible.</li> <li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li> <li>• 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).</li> <li>• <b>YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR ALL NON-EMERGENCY INPATIENT HOSPITAL CARE SERVICES (except for Maternity stays).</b> Please refer to the preauthorization shown in Section 3 to see which services require preauthorization.</li> </ul>	<b>I M P O R T A N T</b>
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Benefit Description	You pay
<b>Inpatient hospital</b>	
<p>Room and board, such as:</p> <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations</li> <li>• General nursing care</li> <li>• Meals and special diets</li> </ul> <p>Note: Your physician may prescribe accommodations or private duty nursing care if is medically necessary. If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	Nothing

*Inpatient hospital – continued on next page*

<b>Inpatient hospital</b> <i>(continued)</i>	<b>You Pay</b>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Administration of blood and blood products</li> <li>• Blood or blood plasma. The collection and storage of autologous blood for elective surgery is covered when authorized by a Plan physician</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</li> </ul> <p>Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The conditions for which we will provide hospitalization include hemophilia and heart disease. The need for anesthesia, by itself, is not such a condition.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals, and beds</i></li> <li>• <i>Private nursing care</i></li> <li>• <i>Any inpatient dental procedures, except as shown above and in Section 5(h) under dental benefits</i></li> <li>• <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient</i></li> </ul>	<i>All charges</i>

<b>Outpatient hospital or ambulatory surgical center</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient</i></li> </ul>	<i>All charges</i>
<b>Extended care benefits/skilled nursing care facility benefits</b>	<b>You pay</b>
<p>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:</p> <ul style="list-style-type: none"> <li>• Physician and nursing services</li> <li>• Room and board</li> <li>• Medical social services</li> <li>• Blood, blood products, and their administration</li> <li>• Durable medical equipment ordinarily furnished by a skilled nursing facility, including oxygen-dispensing equipment and oxygen</li> <li>• Respiratory therapy</li> <li>• Biological supplies</li> <li>• Medical supplies</li> </ul>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Custodial care in an intermediate care facility</i></li> <li>• <i>Custodial care</i></li> </ul>	<i>All charges</i>

<b>Hospice care</b>	<b>You pay</b>
<p>Supportive and palliative care for a terminally ill member:</p> <ul style="list-style-type: none"> <li>• You must reside in the service area</li> <li>• Services are provided in the home</li> <li>• Services are provided in a Plan approved hospice facility</li> </ul> <p>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.</p> <p>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.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Independent nursing</i></li> <li>• <i>Homemaker services</i></li> </ul>	<i>All charges</i>
<b>Ambulance</b>	
<ul style="list-style-type: none"> <li>• Local professional ambulance service when ordered or authorized by a Plan physician</li> </ul>	\$50 per trip
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Transports that we determine are not medically necessary</i></li> </ul>	<i>All charges</i>



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## Section 5 (d). Emergency services/accidents

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<b>I M P O R T A N T</b>	<p>Here are some important things to keep in mind about these benefits:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• We do not have a calendar year deductible.</li><li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li></ul>	<b>I M P O R T A N T</b>
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### 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 a medical emergency:

If you have a medical emergency, dial 911 or go to the nearest emergency room.

### Emergencies within our service area:

Emergency care is provided at Plan Hospitals 24 hours a day, seven day a week. The location and phone number of your nearest Kaiser Permanente hospital may be found in your FEHBP Facility Guide.

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 the Plan within 48 hours, unless it was not reasonably possible to do so.

If you need to be hospitalized, the Plan must be notified within 24 hours or as soon as reasonably possible. 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 on the first working day following your admission, unless it was not reasonable possible to notify the Plan within that time. If a Plan physician believes care can be better provided in a Plan hospital, then 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 Member Services Department in the Atlanta area at 404/261-2590, or from other areas at 800/611-1811.

Benefit Description	You pay
<b>Emergency within our service area</b>	
<p>Emergency care as an outpatient or inpatient at a hospital, including physicians' services</p> <ul style="list-style-type: none"> <li>• Emergency care at an urgent care center not designated by the plan</li> <li>• Emergency care in a hospital emergency room</li> </ul> <p>Note: Your copayment is waived if you are admitted to a hospital.</p>	\$50 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Elective care</i></li> <li>• <i>Non-emergency care</i></li> </ul>	<i>All charges</i>
<b>Emergency outside our service area</b>	
<p>Emergency care as an outpatient or inpatient at a hospital, including physicians' services</p> <ul style="list-style-type: none"> <li>• Emergency care at a physician's office</li> <li>• Emergency care at an urgent care center</li> <li>• Emergency care in a hospital emergency room</li> <li>• Emergency care in a Kaiser Foundation hospital in another Kaiser Foundation Health Plan service area</li> </ul> <p>Note: See the Travel Benefit for coverage of continuing or follow-up care.</p>	<p>\$50 per visit</p> <p>The amount you would be charged if you were a member in that service area</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Elective care or non-emergency care</i></li> <li>• <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li>• <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All charges</i>
<b>Ambulance</b>	
Professional ambulance service when medically appropriate	\$50 per trip
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation, even if it is the only way to travel to a facility</i></li> <li>• <i>Transports we determine are not medically necessary</i></li> </ul>	<i>All charges</i>

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

<b>I M P O R T A N T</b>	<p><b>Here are some important things to keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are clinically appropriate to treat your condition.</li> <li>• Plan physicians must provide or arrange your care.</li> <li>• We have no calendar year deductible.</li> <li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li> </ul>	<b>I M P O R T A N T</b>
Benefit Description		You pay
<b>Mental health and substance abuse benefits</b>		
<p>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.</p> <p>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.</p> <p>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 conditions of another.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or.</p>	

*Mental health and substance abuse benefits – continued on next page*

Mental health and substance abuse benefits <i>(continued)</i>	You pay
<p>Diagnosis and treatment of psychiatric, mental illness, or disorders of children, adolescents, and adults. Services include:</p> <ul style="list-style-type: none"> <li>• Diagnostic evaluation</li> <li>• Crisis intervention and stabilization for acute episodes</li> <li>• Psychological testing to determine the appropriate psychiatric treatment</li> <li>• Outpatient psychiatric treatment (including individual and group therapy visits)</li> <li>• Medication evaluation and management</li> </ul> <p>Diagnosis and treatment of alcoholism and drug abuse. Services include:</p> <ul style="list-style-type: none"> <li>• Detoxification (medical management of withdrawal from the substance)</li> <li>• Treatment and counseling (including individual and group therapy visits)</li> <li>• Rehabilitative care</li> </ul> <p>Note: You may see an outpatient mental health or substance abuse provider without a referral from your primary care physician. See Section 3, <i>How you get care</i> for information about services requiring our prior approval.</p> <p>Note: Your mental health or substance abuse provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you.</p>	<p>\$10 per office visit for individual therapy</p> <p>\$5 per office visit for group therapy</p>

*Mental health and substance abuse benefits – continued on next page*

Mental health and substance abuse benefits <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Inpatient mental health and substance abuse care</li> <li>• Hospital alternative services, such as partial hospitalization and intensive outpatient psychiatric treatment programs</li> </ul> <p>Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan physician.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Care that is not clinically appropriate for the treatment of your condition</i></li> <li>• <i>Services we have not approved</i></li> <li>• <i>Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition</i></li> <li>• <i>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</i></li> <li>• <i>Services that are custodial in nature</i></li> <li>• <i>Services rendered or billed by a school or a member of its staff</i></li> <li>• <i>Services provided under a federal, state, or local government program</i></li> <li>• <i>Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms</i></li> </ul>	<i>All charges</i>

**Limitation**

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

## Section 5 (f). Prescription drug benefits

<b>I M P O R T A N T</b>	<p><b>Here are some important things to keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>• We cover prescribed drugs and medications, as described in the chart beginning on the next page.</li> <li>• 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.</li> <li>• We have no calendar year deductible.</li> <li>• Your physician must get preauthorization for certain drugs. Certain prescription drugs require approval prior to dispensing. The list of prescription drugs that require preauthorization is subject to periodic review and modification. If you would like to know if a drug requires preauthorization you may contact our Member Services Department at 404/261-2590.</li> <li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li> </ul>	<b>I M P O R T A N T</b>
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**There are important features you should be aware of.** These include:

- **Who can write your prescription.** A Plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan medical office pharmacy or a Plan participating community pharmacy.

It may be possible for you to receive certain refills by mail at no extra charge. You can order prescription refills for mail delivery three ways:

1. Online, using our Members Only website [www.kponline.org](http://www.kponline.org). This site requires online registration. You can choose to have your prescriptions mailed to your home or to a Plan medical office pharmacy for you to pick up. Online prescription orders must be paid for in advance, by a credit card; or
2. Call our toll-free pharmacy mail-order line at 888/662-4579, weekdays from 9:00 a.m. to 6:00 p.m. Mail-order prescriptions must be paid for in advance by a credit card; or
3. Fill out and send in your request by using one of our mail-order pharmacy envelopes. You can order a supply by calling our Member Services Department at 404/261-2590. When you use this method of ordering, you can pay by check or credit card.

Allow at least two weeks for the prescription to be filled and delivered to you by mail. Also keep in mind that some medicines, such as those requiring refrigeration and controlled medications, are not available through mail-order.

We pay a higher level of benefits when you use a Plan medical office pharmacy.

- **We use a formulary.** We use a formulary, which is a listing of preferred pharmaceutical substances and formulas that our physicians and pharmacists consider to be the most safe, useful and cost-effective ones available. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. Coverage for prescription drugs is limited to those drugs that are included on the Kaiser Permanente 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 prescription drug copayment would apply. This formulary exception process does not apply to your dentist. In order to be covered at your prescription drug copayment all prescriptions written by your dentist must be included on the Kaiser Permanente formulary.

Unless otherwise specified by your Plan physician or dentist, generic drugs may be used to fill a prescription. If you request a brand name at Plan pharmacy or Plan participating community pharmacy, you pay the cost difference between the generic and brand name drugs, in addition to the applicable copayment.

If you would like information about whether a particular drug is included in our drug formulary, or a list of our formulary drugs, please call our Member Services Department at 404/261-2590.

- **These are the dispensing limitations.** Up to the lesser of a 30 day supply or the standard prescription amount of prescribed covered drugs and certain supplies. For example, the standard prescription amount for insulin is one 10 milliliter vial, and the standard prescription amount for migraine medications, ophthalmic, otic and topical medications, and for oral and nasal inhalers, is the smallest standard package size available. Drugs to treat sexual dysfunction have dispensing limitations. Contact us for details.
- **Why use generic drugs?** The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your Plan less money than a name-brand drug, and are a safe and economic way to meet your prescription drug needs.
- **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.

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*Prescription drug benefits begin on the next page.*

Benefit Description	You pay
<b>Covered medications and supplies</b>	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs for which a prescription is required by law</li> <li>• Diabetic supplies such as glucose test strips (Chemstrip®), Dextrostix®, sugar test tape, sugar test tablets, acetone test tablets</li> <li>• Inhalers</li> <li>• Spacer devices</li> <li>• Compounded dermatological preparation prepared by a pharmacist</li> <li>• Oral contraceptive drugs</li> <li>• Diaphragms</li> <li>• Growth hormone therapy (GHT) – for treatment of children with Turner’s syndrome or classical growth hormone deficiency</li> </ul>	<p>\$10 per prescription or refill if obtained at a Plan medical office pharmacy</p> <p>\$16 per prescription or refill if obtained at a Plan participating community pharmacy</p>
<ul style="list-style-type: none"> <li>• Insulin</li> </ul>	<p>\$10 per vial or refill if obtained at a Plan medical office pharmacy</p> <p>\$16 per vial or refill if obtained at a Plan participating community pharmacy</p>
<ul style="list-style-type: none"> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Intravenous fluids and medications for home use</li> <li>• Amino acid-modified products used to treat congenital errors of amino acid metabolism</li> <li>• Post-surgical immunosuppressant outpatient drugs required as a result of a covered transplant</li> </ul>	<p>Nothing</p>
<ul style="list-style-type: none"> <li>• Implanted time-release contraceptive drugs</li> </ul>	<p>\$180</p>
<ul style="list-style-type: none"> <li>• Other implanted time release drugs</li> <li>• Injectable contraceptive drugs</li> </ul> <p>Note: We do not refund any portion of your copayment if you request removal of the implanted drug time-release medication before the end of its expected life.</p>	<p>\$10 times the number of months the drug is expected to be effective, not to exceed \$200</p>
<ul style="list-style-type: none"> <li>• Intrauterine devices</li> </ul>	<p>\$50 per device</p>

*Covered medications and supplies – continued on next page*



Covered medications and supplies <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Drugs for covered infertility treatments</li> <li>• Drugs for sexual dysfunction</li> </ul> <p>Note: Drugs to treat sexual dysfunction have dispensing limitations.</p>	50% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Vitamins and nutritional supplements that can be purchased without a prescription</i></li> <li>• <i>Nonprescription drugs</i></li> <li>• <i>Prescription drugs for which there is a nonprescription equivalent available</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i></li> <li>• <i>Medical supplies such as dressings and antiseptics</i></li> <li>• <i>Any packaging other than the dispensing pharmacy's standard packaging</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Drugs related to non-covered infertility services</i></li> <li>• <i>Contraceptive devices, except diaphragms and intrauterine devices</i></li> <li>• <i>Smoking cessation drugs and medications, including nicotine patches</i></li> <li>• <i>Drugs for non-covered services</i></li> <li>• <i>Packaging of prescription medications is limited to Plan standard packaging; special packaging is not covered</i></li> <li>• <i>Replacement of lost, stolen, or damaged drugs and accessories</i></li> <li>• <i>Infant formulas, except for amino acid-modified products noted above</i></li> </ul>	<i>All charges</i>

## Section 5 (g). Special features

Feature	Description
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit</li> <li>• We review alternative benefits on an ongoing basis</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future</li> <li>• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits</li> <li>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process</li> </ul>
<b>24 hour nurse line</b>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 404/365-0966 (locally) or 800/611-1811 (long distance) and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>
<b>Services for deaf and hearing impaired</b>	<p>Our hearing and speech impaired TTY number is: 800/255-0056.</p>
<b>High risk pregnancies</b>	<p><b>Comprehensive Maternity Program.</b> The goal is to significantly reduce the incident of pre-term deliveries and low birth weight babies by prompt interventions utilizing a multidisciplinary team approach.</p> <p>All women receiving prenatal care are assessed at the first provider visit (ideally during the first trimester) for factors associated with high-risk pregnancy. Risk scoring systems are based on a combination of past medical history (particularly reproductive history), current pregnancy events, personal habits during pregnancy, and demographic risks.</p> <p>Although risk scoring can identify some individuals at risk during pregnancy, no scoring system is so effective that those at risk may be safely ignored. Therefore, ongoing assessment must be done for all patients for symptoms and risk factors for pre-term birth.</p> <p>We are not able to implement any aspect of our maternity benefits on a "mandatory" basis. However, because copayments are waived for all prenatal and one postnatal visit, we have a 99% compliance with the recommended course of treatment.</p>
<b>Centers of excellence</b>	<p>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.</p> <p>We have developed a network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation, and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.</p>

Feature	Description
<p><b>Travel benefit</b></p>	<p>Kaiser Permanente’s travel benefits for Federal employees provide you with outpatient follow-up or continuing medical care when you are temporarily outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency and urgent care benefits and include:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• 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</li> <li>• You pay \$25 for each follow-up or continuing care office visit. We deduct this amount from the payment we make to you</li> <li>• We pay no more than \$1200 each calendar year</li> <li>• For more information about this benefit call the Travel Benefit Information Line at 800/390-3509</li> <li>• File claims as shown on page 54.</li> </ul> <p><i>The following are not included in your travel benefits coverage:</i></p> <ul style="list-style-type: none"> <li>• <i>Non-emergency hospitalization</i></li> <li>• <i>Infertility treatments</i></li> <li>• <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> <li>• <i>Transplants</i></li> <li>• <i>DME</i></li> <li>• <i>Prescription drugs</i></li> <li>• <i>Home health services</i></li> </ul>
<p><b>Smoking cessation</b></p>	<p>Kaiser Permanente offers smoking cessation classes as described under Educational classes and programs in Section 5(a). In addition to the classes we also offer the following:</p> <ul style="list-style-type: none"> <li>• Free brochures</li> <li>• Bookmark listing of smoking cessation resources</li> <li>• Quarterly smoking cessation resource outreach mailings to all identified smokers</li> <li>• Smoking cessation self-help booklet for pregnant women</li> <li>• Smoking cessation brochure for teens</li> </ul> <p>For more information or to order any of the above materials please call our Member Services Department at 404/261-2590.</p>

Feature	Description
<p><b>Services from other Kaiser Permanente plans</b></p>	<p>When you visit the service area of another Kaiser Permanente plan, you are entitled to receive virtually all the benefits described in this brochure (including our mail order prescription program) at any Kaiser Permanente medical office or medical center. You must pay the charges or copayments imposed by the Kaiser Permanente Plan you are visiting, with the exception of mail order prescriptions which are administered by your home Plan. You will have to pay the copayments or other charges imposed by the Plan you are visiting. If the Plan you are visiting has a benefit that differs from the benefits of this Plan, you are not entitled to receive that benefit.</p> <p>Some services covered by this Plan, such as artificial reproductive services and the services of specialized rehabilitation facilities, will not be covered if you receive them in other Kaiser Permanente service areas. If a benefit is limited to a specific number of visits or days, you are entitled to receive only the number of visits or days covered by this Plan.</p> <p>If you are seeking routine, non-emergent, or non-urgent services, you should call the Kaiser Permanente Membership Services department in that service area and request an appointment. You may obtain routine follow-up or continuing care from these Plans, even when you have obtained the original services in our service area. If you require emergency services as the result of unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care.</p> <p>At the time you register for services, you will be asked to pay the charges required by the local Plan.</p> <p>If you wish to obtain more information about the benefits available to you from a Kaiser Permanente Plan in an area you visit, please call our Member Services Department at 404/261-2590 or 800/611-1811.</p>

## Section 5 (h). Dental benefits

<b>I M P O R T A N T</b>	<p><b>Here are some important things to keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we pay them only when we determine they are medically necessary.</li> <li>• Plan dentists must provide or arrange your care. Call Member Services for a list of participating dentists.</li> <li>• We have no calendar year deductible.</li> <li>• 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.</li> <li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li> </ul>	<b>I M P O R T A N T</b>
<b>Dental Benefits</b>		<b>You pay</b>
<b>Accidental injury benefit</b>		
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury and all services must be completed within 365 days of the injury.	50% of the first \$1,000 of our allowance per calendar year; all charges thereafter	

Other dental benefits	You Pay
We cover non-surgical treatment of temporomandibular joint dysfunction (TMJ), including splints and appliances	50% of our allowance
<p>The following preventive dental services are covered when provided by a participating Plan dentist:</p> <ul style="list-style-type: none"> <li>• Oral examinations twice a year</li> <li>• Dental prophylaxis (cleaning) twice a year</li> <li>• Topical application of fluoride twice a year</li> <li>• Bitewing X-ray twice a year</li> <li>• Full mouth series X-rays once every three years</li> </ul> <p>Note: You receive a 10% discount from the Plan dentist's usual and customary fee schedule for all other dental care.</p>	\$14 per office visit
<p>General anesthesia and associated hospital or ambulatory surgery facility charges in conjunction with dental care are covered for persons:</p> <ul style="list-style-type: none"> <li>• 7 years of age or younger</li> <li>• Who are developmentally disabled</li> <li>• Who are not able to have dental care under local anesthesia due to a neurological or medically compromising condition</li> <li>• Who have sustained extensive facial or dental trauma</li> </ul>	Nothing
Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease	\$10 per office visit
<p><i>Not covered</i></p> <ul style="list-style-type: none"> <li>• <i>Other dental services not specifically shown as covered</i></li> </ul>	<i>All charges</i>

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

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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.

### Expanded Dental Care

We are pleased to offer you and your family expanded dental coverage through the American Dental Plan.

CompDent Corporation offers you dental health maintenance organization benefits administered by American Dental Plan (ADP). You must choose a primary care dentist from the list of ADP dentists that is most convenient to you and your family. With ADP you have no claim forms to worry about. ADP provides a full range of services such as: preventive, restorative, endodontics, periodontics, prosthetics, and orthodontics. Under this program, you pay discounted rates for all covered services.

### Monthly Premium\*

Self Only	\$ 12.74
Self & One Party	\$ 23.30
Self & Two or More	\$ 33.50

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

### How To Enroll

Please read the enclosed flyer for a summary of the expanded dental plan. If you would like more information call 770/649-1506 or send an e-mail to: [brendaj@america.net](mailto:brendaj@america.net), and identify yourself as an Federal employee interested in the Kaiser Permanente/CompDent expanded dental care option.

You must pay the monthly premium by automatic monthly withdrawal from your checking, savings, or credit union account or an annual charge to your MasterCard or Visa.

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### SelfWise Program

As a Kaiser Permanente member, you're automatically enrolled in our *SelfWise* Program. This program gives you easy access to products and services you can use to enhance your health and improve your quality of life. *SelfWise* offers discounted rates for chiropractic, accupressure, and massage therapy services through our Complementary and Alternative Medicine (CAM) program; discounted products and services from local businesses and health clubs; vision care discounts, competitively priced over-the-counter items at our Kaiser Permanente Medical Center pharmacies; and complete overseas travel vaccinations from our international travel service.

Note: Keep in mind that these programs are discount programs. They are not a part of your FEHP benefits. These discounted programs are made available to all enrollees and family members who are members of Kaiser Permanente.

### Laser Vision Correction Program

As a Kaiser Permanente member, you're entitled to participate in our Laser Vision Center Correction Program. Members can receive certain LASIK procedures at reduced rates from TLC Laser Eye Centers. For more information about the Laser Vision Correction Program, contact our Member Services Department at 404/240-0303.

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## Section 6. General exclusions – things we don't cover

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

We do not cover the following:

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



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## Section 7. Filing a claim for covered services

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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 404/261-2590.

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 Permanente  
Claims Administration  
P.O. Box 190849  
Atlanta, GA 31119-0849

### **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.

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## Section 8. The disputed claims process

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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 preauthorization:

Step	Description
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- |          |  |
|----------|--|
| <b>1</b> | <p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"><li>Write to us within 6 months from the date of our decision; and</li><li>Send your request to us at: Kaiser Foundation Health Plan of Georgia, Inc., Attention: Appeals Department, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta GA 30305-1736; and</li><li>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ol> |
| <b>2</b> | <p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"><li>Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>Write to you and maintain our denial -- go to step 4; or</li><li>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.</li></ol>  |
| <b>3</b> | <p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>  |
| <b>4</b> | <p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>90 days after the date of our letter upholding our initial decision; or</li><li>120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or</li><li>120 days after we asked for additional information.</li></ul> <p>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3620.</p>  |

Send OPM the following information:

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

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

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

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

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

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 404/261-2590 and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/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.

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## Section 9. Coordinating benefits with other coverage

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**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 or our regular benefit. We will not pay more than our allowance. If we are the secondary payer, and you received your services from Plan providers, we may bill the primary carrier.

- **What is Medicare?**

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 404/233-3700 (locally), 800/232-4404 (long distance) and 800/255-0056 (TTY line).

**(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.

<b>Primary Payer Chart</b>		
<b>A. When either you -- or your covered spouse -- are age 65 or over and ...</b>	<b>Then the primary payer is...</b>	
	<b>Original Medicare</b>	<b>This Plan</b>
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>B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and...</b>		
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,	✓	
<b>C. When you or a covered family member have FEHB and...</b>		
1) Are eligible for Medicare based on disability, and	✓	
a) Are an annuitant, or		
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

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

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

**This Plan and our Medicare managed care plan:** You may enroll in our Medicare managed care plan, known as Medicare+Choice or Kaiser Permanente Senior Advantage, and also remain enrolled in our FEHB Plan. There is no additional premium to enroll in Senior Advantage. In this case, we waive or lower some of our copayments and coinsurance for your FEHB and Medicare coverage. If you would like information about our Medicare+Choice plan, please call weekdays, 8:30 a.m. to 5:00 p.m., 404/233-3700 (locally), 800/232-4404 (long distance) and 800/255-0056 (TTY line). Your Kaiser Permanente Senior Advantage-FEHB benefits that we lowered or waived are:

- **Physician office visits:** \$5 copayment for physician/specialist visit
- **Preventive care:** \$5 copayment per visit for most adult preventive care services; no copayment for mammograms
- **Routine physicals and hearing exams:** \$5 copayment per visit
- **Outpatient mental health and substance abuse:** \$5 copayment per visit
- **Prescriptions:**
  - \$3 for each generic/brand prescription obtained at a Plan medical office pharmacy
  - \$9 for each generic/brand prescription obtained at a Plan participating community pharmacy
- **Dialysis:** no copayments
- **Durable medical equipment:** no copayments
- **Orthopedic and prosthetic devices:** no copayments
- **Vision Services:**
  - \$15 copayment for one routine eye exam each year
  - \$40 frame allowance for one frame every two years; \$60 allowance for cosmetic contact lenses in lieu of eyeglasses once every two years

**You will also enjoy:**

- Health/Wellness Education: \$5 copayment for disease-specific health education classes (costs may vary for wellness classes)
- No deductibles and virtually no paperwork
- On-line access to health information and resources at our award-winning members only website
- Quarterly member communication in our "Senior Outlook" magazine
- Customized Senior Advantage new member orientation.

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

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

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

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

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.

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## Section 10. Definitions of terms we use in this brochure

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<b>Calendar year</b>	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.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	(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 whom, 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.
<b>Deductible</b>	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.
<b>Durable medical equipment</b>	Durable medical equipment (DME) is equipment that is intended for repeated use, medically necessary, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, designed for prolonged use, appropriate for use in the home, and serves a specific therapeutic purpose in the treatment of an illness or injury.
<b>Experimental or investigational services</b>	We carefully evaluate whether a particular therapy is safe and effective or offers a reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental literature. When the service or supply, including a drug: (1) has not been approved by the FDA; or (2) is the subject of a new drug or new device application on file with the FDA; or (3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or (4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or (5) is subject to the approval or review of an Institutional Review Board; or (6) requires an informed consent that describes the service as experimental or investigational; then this Plan considers that service supply or drug to be experimental, and not covered by the Plan.
<b>Group health coverage</b>	Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other

managed care plans. Health care coverage purchased through membership in an organization is also "group health coverage."

**Medically necessary**

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

**Our allowance**

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

**Us/We**

Us and we refer to Kaiser Foundation Health Plan of Georgia, Inc.

**You**

You refers to the enrollee and each covered family member.

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## Section 11. FEHB facts

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### 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](http://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 option of the Blue Cross and Blue Shield Service Benefit Plan's Basic Option that provides the lower level of coverage;
- 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 your employing office for further information.

## **When benefits and premiums start**

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

## **When you retire**

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

## **When you lose benefits**

### **• When FEHB coverage ends**

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

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

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

### **• Spouse equity coverage**

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

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

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## Long Term Care Insurance Is Still Available!

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### 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](http://www.ltcfeds.com)** to get more information and to request an application.



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## Summary of benefits for Kaiser Foundation Health Plan of Georgia, 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 office visit	16
Services provided by a hospital:		
• Inpatient .....	Nothing	34
• Outpatient .....	Nothing	36
Emergency benefits:		
• In-area .....	\$50 per visit	38
• Out-of-area .....	\$50 per visit	38
Mental health and substance abuse treatment: .....	Regular cost sharing	40
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## Notes

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## 2003 Rate Information for Kaiser Foundation Health Plan of Georgia, 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 special a 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.

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Self Only	F81	\$86.38	\$28.79	\$187.16	\$62.38	\$102.21	\$12.96
Self and Family	F82	\$219.29	\$73.10	\$475.13	\$158.38	\$259.50	\$32.89