



A Health Maintenance Organization



This Plan has full accreditation from NCQA. See the 1998 Guide for more information on NCQA.

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

You must live or work in the service area to enroll in this plan.

Enrollment code:

E31 Self only

E32 Self and family

Service area: Services from Plan providers are available only in the area described on page 8.

Visit this Plan's WEB page at <http://www.kaiseronline.org>

Authorized for distribution by the:



**United States
Office of
Personnel
Management**



RI 73-047

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 East Jefferson Street, Rockville, MD 20849 has entered into a contract (CS 1763) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Kaiser Permanente or the Plan.

This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. A person enrolled in the Plan is entitled to the benefits stated in this brochure. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1998, and are shown on page 23.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 301/468-6000 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write::

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 13. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hospitalized" on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

General Information *continued*

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who family members are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements

Separating employees — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Notification and election requirements

Children — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available—or chosen—when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for pre-existing conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Facts about this Plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays them directly for their services. Benefits are available from Plan providers except during a medical emergency. Members are required to select a personal doctor from among participating Plan primary care doctors. Services of a specialty care doctor can only be received by referral from the selected primary care doctor. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the Plan's benefits and delivery system, not because a particular provider is in the Plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Who provides care to Plan members?

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is a Federally qualified Health Maintenance Organization. The Plan has been delivering prepaid health services to Washington, D.C., area residents since December 1972. Presently it serves nearly 500,000 members in the Washington, D.C., and Baltimore, Maryland metropolitan areas.

This Plan offers comprehensive health care coverage on a prepaid group practice basis through Plan Medical Centers and other designated locations conveniently located throughout the Washington, D.C., and Baltimore, Maryland metropolitan areas. Except in emergencies, all care is provided at these facilities or otherwise arranged by the Plan. Health Plan contracts with the Mid-Atlantic Permanente Medical Group, P.C. ("Plan doctors"), an independent multi-specialty group of physicians, to provide or arrange all necessary physician care for Plan members. These Plan doctors are members of American Specialty Boards or are Board eligible. Medical care is provided through Plan doctors and

Facts about this Plan *continued*

other qualified medical personnel working together at Plan Medical Centers and other designated locations. Other necessary medical services are also available at Plan Medical Centers. Plan doctors also arrange any necessary specialty care. Hospital care is provided at local community hospitals.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other Plan providers are covered only when there has been a referral by the member's primary care doctor.

Choosing your doctor

The Plan's provider directory lists primary care doctors (general practitioners, pediatricians, and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Services Department at 301/468-6000 or 1-800-777-7902; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.

If you enroll, you will be asked to select a primary care doctor for you and each member of your family and inform your Plan of your choice. You are free to see other Plan doctors if your primary care doctor is not available, and to receive care at other Kaiser Permanente facilities. Members may change their doctor selection by notifying the Plan at any time.

If you are receiving services from a Plan doctor who terminates his or her association with the Plan, the Plan will provide payment for covered services until the Plan can make reasonable and medically appropriate provisions for the assumption of such services by another Plan doctor.

Referrals for specialty care

Except in a medical emergency, you must contact your primary care doctor for a referral before seeing any other doctor or obtaining special services. Referral to a Plan specialist is given at the primary care doctor's discretion; if specialists or consultants are required beyond those who are Plan doctors, the primary care doctor will make arrangements for appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation. All follow-up care must be provided or arranged by the primary care doctor. On referrals, your primary care doctor will give specific instructions to the consultant as to what services are authorized. If additional services or visits are suggested by the consultant, you must first check with your primary care doctor. Do not go to the specialist unless your primary care doctor has arranged for and the Plan has issued an authorization for the referral in advance.

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor must obtain the Plan's determination of medical necessity before you may be hospitalized, referred for specialty care or obtain follow-up care from a specialist.

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan.

If you are selecting a new primary care doctor and want to continue with this specialist, you must schedule an appointment so that the primary care doctor can decide whether to treat the condition directly or refer you to a specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for a few benefits, such as prescription drugs, mental health and substance abuse treatments and the copayments required for dental services.

Facts about this Plan *continued*

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's service areas

The service area for this Plan, where Plan providers and facilities are located, is described on the front cover of this brochure and on this page. You must live or work in the service area to enroll in this Plan.

The service area for this Plan includes the following areas:

The District of Columbia; the Maryland counties of Montgomery, Prince George's, and the portions of Charles, Calvert and Frederick Counties served by the following zip codes: Charles County 20601, 20602, 20603, 20604, 20612, 20616, 20617, 20637, 20640, 20646, 20658, 20675, 20695; Calvert County 20639, 20689, 20714, 20732, 20736, 20754; Frederick County 21702, 21705, 21709, 21710, 21714, 21716, 21717, 21718, 21754, 21755, 21755, 21758, 21762, 21769, 21770, 21774, 21774, 21777, 21790, 21793; the City of Baltimore, and the counties of Baltimore, Carroll, Hartford, Howard and Anne Arundel counties; the Virginia cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park, as well as the Virginia counties of Arlington, Fairfax, Loudoun, and Prince William.

Benefits for care outside the service area are limited to emergency services, as described on page 13.

If you or a covered family member travels frequently or lives away from home part of the year, you should be aware that benefits for care outside the service area are restricted to emergency care benefits as described on page 13, and care received at Kaiser Permanente facilities in other Kaiser Permanente Regions. Contact the Plan for further details on services available in other Kaiser Permanente Regions. The service area is the area within which the Plan's providers are most accessible. For this Plan, the service area is the same as the enrollment area listed on the front cover of this brochure (the area in which you must live or work to enroll in this Plan).

If you or a covered family member move outside the service area, (or if you no longer work there) you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan. This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

General Limitations *continued*

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, benefits will be coordinated with Medicare according to Medicare's determination of which coverage is primary. Generally, you do not need to take any action after informing the Plan of your or your family member's eligibility for Medicare. Your Plan will provide you with further instructions if a Medicare claim needs to be filed.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary care provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition as discussed under Authorizations on page 7. The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits);
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and 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.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; you pay nothing for office visits or for laboratory tests and X-rays; within the service area house calls will be provided if, in the judgment of the Plan doctor, such care is necessary and appropriate; you pay nothing for, a doctor's house call and nothing for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
Mammograms are covered as follows: for women age 35 through 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and post-natal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Cornea, heart, kidney, liver, lung (single or double), heart/lung and pancreas/kidney transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Related medical and hospital expenses of the donor are covered.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Medical and Surgical Benefits *continued*

- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Home health services provided by nurses and health aides, including intravenous fluids and medication, when prescribed by your Plan doctor, will be provided for homebound members residing in the service area and obstetrical members and newborns who have been discharged from the hospital following obstetrical inpatient care. The Plan doctor will periodically review the home health program for continuing appropriateness and need.
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you
- Gamma globulin

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered (except as shown on pages 17-19 under Dental care) including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two consecutive months per condition if significant improvement can be expected within two months; you pay nothing. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Diagnosis and treatment of infertility is covered; you pay nothing except for certain injectables. The following types of artificial insemination is covered: intracervical insemination (ICI), intrauterine insemination (IUI) and intravaginal insemination (IVI); you pay nothing; cost of donor sperm and eggs and services related to their procurement and storage is not covered. Other assisted reproductive technology (ART) procedures such as in vitro fertilization, gamete and zygote intrafallopian transfers, are not covered. Infertility services are not available when either member of the family has been voluntarily surgically sterilized. Prescribed drugs are covered for covered infertility treatments under the Prescription Drug Benefit.

Durable Medical Equipment for use in the member's home will be provided for up to three months following a hospital confinement.

Chiropractic services are covered in full up to a \$1,000 maximum per calendar year.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, or travel
- Reversal of voluntary, surgically-induced sterility
- Plastic surgery primarily for cosmetic purposes
- External and internally implanted hearing aids
- Homemaker services
- Orthopedic devices, such as braces; foot orthotics
- Prosthetic devices, such as artificial limbs and lenses following cataract removal
- Durable medical equipment, such as wheelchairs, hospital beds and oxygen in the home except as provided for on this page.
- Whole blood, packed red blood cells and anti-hemophilic factors
- Long-term rehabilitative therapy
- Transplants not listed as covered
- Cardiac rehabilitation
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. You pay nothing. All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits for 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 as determined by a Plan doctor and approved by the Plan. You pay nothing. All necessary services are covered, including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home. Services include short-term inpatient care, limited to respite care and care for pain control and acute and chronic symptom management, outpatient care and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. You pay nothing.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. You pay nothing.

Limited benefits

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 15 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Whole blood, packed red blood cells and anti-hemophiliac factors
- Custodial care, or care in an intermediate care facility

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Emergency Benefits

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that 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 the Plan may determine are medical emergencies—what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call the Plan's 24-hour emergency number—1-800/677-1112. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. 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. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred 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.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays . . .

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay . . .

\$35 per hospital emergency room visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is waived at the admitting hospital.

Emergencies outside the 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 reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays . . .

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay . . .

\$35 per hospital emergency room visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is waived at the admitting hospital.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan
- Up to \$500 per member per calendar year for medically necessary outpatient follow up treatment, received after obtaining approved emergency services outside the service area.

Emergency Benefits *continued*

What is not covered

- Elective care
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 21.

Mental Conditions/Substance Abuse Benefits

Mental conditions

- What is covered** To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:
- Diagnostic evaluation
 - Psychological testing
 - Psychiatric treatment (including individual and group therapy)
 - Hospitalization (including inpatient professional services)
- Outpatient care** Unlimited visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; you pay nothing for the 1st through 5th visits; thereafter, you pay \$10 for an individual visit and \$5 for group visits 6 through 20; then \$30 for an individual visit and \$5 for group visits for the remainder of the calendar year.
- Inpatient care** Unlimited number of days each calendar year; you pay nothing.
- What is not covered**
- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
 - Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
 - Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance abuse

- What is covered** This Plan provides medical and hospital services such as acute detoxification services, for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and to the extent shown below, the services necessary for diagnosis and treatment.
- Outpatient care** Outpatient visits to Plan providers for treatment; you pay nothing for each visit.
- Inpatient care** Acute detoxification; the Plan provides unlimited number of days for rehabilitative services in a hospital or specialized facility; you pay nothing.
- What is not covered**
- Treatment that is not authorized by a Plan doctor
 - Methadone treatment for narcotic addiction

Prescription Drug Benefits

- What is covered** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 90-day supply based upon the prescribed dosage and standard manufacturer's package size. You pay a \$7 copay per prescription unit or refill for drugs purchased at a Plan pharmacy or \$4 per prescription unit or refill obtained through the Plan's mail order program. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug) but you request the name brand drug, you pay a \$15 charge for the name brand drug as well as the \$7 copay (or \$4 copay if requested through mail order) per prescription unit or refill. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Nonformulary drugs will be covered when prescribed by a Plan doctor. Dental prescriptions are limited to formulary products for pain relief and antibiotics only.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Prescription Drug Benefits *continued*

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Implanted time release medications; you pay a one-time copayment equal to the \$7 per prescription charge times one half the expected number of months the medication will be effective, not to exceed \$200. There will be no refund of any portion of these copayments if the implanted time release medication is removed before the end of its expected life.
- Oral contraceptive drugs and the implanted time release contraceptive, Norplant (You pay a \$200 copay for Norplant, with no refund if it is removed before the end of its expected life)
- Injectable contraceptive drugs
- Insulin
- Diabetic supplies including disposable insulin syringes, needles, blood glucose test strips, and acetone test tablets
- Disposable needles and syringes needed for self injection of covered prescribed drugs
- Self injectable drugs, other than ovulation stimulants, you pay \$7 per prescribed therapeutic course of treatment
- Ovulation stimulants, you pay 25% of the average wholesale price (AWP)
- Diaphragms/IUDs (you pay a \$100 copayment for an IUD)
- Medical food and low protein modified food products for the therapeutic treatment of inherited metabolic diseases
- Medications for treatment of erectile dysfunction, including but not limited to Caverject and Muse; you pay 50% of the average wholesale price (AWP)
- Intravenous fluids and medication for home use, some implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits (as home health services)

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Drugs related to non-covered infertility services
- Smoking cessation drugs and medications

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Other Benefits

Dental care

What is covered

The following dental services are covered when provided by participating Plan general dentists. You pay copayments when services are performed by a general dentist. Services of a specialist can only be received by referral from a Plan general dentist. Higher copayments may apply for services received from a specialist.

Preventative and diagnostic services:

Initial and periodic examinations, bitewing X-rays, cleaning of teeth (prophylaxis) every six months, topical fluoride treatments, and preventive care training: You pay a \$30 copayment per member per visit.

Schedule of dental services and fees:

Dental Services

PROCEDURE NAME	You Pay*	PROCEDURE NAME	You Pay*
<u>ADA</u> <u>Diagnostic:</u>		2931 Prefab Stainlss Steel Crwn-Perm Tooth	\$100
0210 Intraoral-Coml Ser Incl Bitewings	\$30/33	2932 Prefabreinted Resin Crown	140
0330 Panoramic X-Rays	25/28	2940 Sedative Fillings	30
046 Pulp Vitality Tests	/14	2950 Crown Buildup-including any Pins	90
0470 Diagnostic Casts	/29	2951 Pin Reten-Per Tooth in Add to Resto	20
		2952 Cast Post & Core in Add to Crown	130
<u>ADA</u> <u>Preventative:</u>		2954 Prefab Post & Core in Add to Crown	115
1351 Sealant-Per Tooth	15	2970 Temporary Crown (Fractured Tooth)	75
1510 Space Maintainer-Fixed Unilateral	164	2980 Crown Repair	75
1515 Space Maintainer-Fixed Bilateral	164		
1520 Space Maintainer-Removable Unilateral	202	<u>ADA</u> <u>Endodontics:</u>	
1525 Space Maintainer-Removable Bilateral	126	3110 Pulp Cap-Direct EXCL Final Rest	\$20/21
1550 Recementation of Space Maintainer	19	3120 Pulp Cap-Indirect EXCL Final Rest	20/21
		3220 Therapeutic Pulpotomy Excl Final Rest	50/60
<u>ADA</u> <u>Restorative:</u>		3310 One Canal Excl Final Restoration	214/270
2110 Amalgam-One Surface Primary	\$24	3320 Two Canals Excl Final Restoration	249/420
2120 Amalgam-Two Surfaces Primary	31	3330 Three Canals Excl Final Restoration	265/520
2130 Amalgam-Three Surfaces Primary	35	3350 Apexification-Per Treatment	105/146
2131 Amalgam-Four+ Surfaces Primary	45	3410 Apicoectomy/Periadicular Surg-Ant	132/340
2140 Amalgam-One Surface Permanent	27	3421 Apico/Perirad Surg-Bicus First Root	132/415
2150 Amalgam-Two Surfaces Permanent	35	3425 Apico/Perirad Surg-Molar First Root	32/435
2160 Amalgam-Three Surfaces Permanent	43	3426 Apico/Perirad Srg-Molar Ea Add Root	4/165
2161 Amalgam-Four+ Surfaces Permanent	51	3430 Retrograde Filling-Per Root	93/175
2330 Resin-One Surface Anterior	33	3450 Root Amputation-Per Root	93/225
2331 Resin-Two Surfaces Anterior	43	3920 Hemisect W Rt Tem-W/O Canal Ther	112/200
2332 Resin-Three Surfaces Anterior	52		
2335 Resin-3+ Surf or Involving Incisal Angle	56	<u>ADA</u> <u>Periodontics:</u>	
2510 Inlay-Metallic-One Surface	290	4210 Gingivectomy/Gingivoplasty-Per Quad	\$198/265
2520 Inlay-Metallic-Two Surfaces	315	4221 Gingivectomy/Gingivoplasty-Per Tooth	53/80
2530 Inlay-Metallic-Three Surfaces	350	4220 Gingival Curettage-Per-Quad	60/125
2540 Onlay-Metallic-Per-Tooth In Add To Inlay	385	4240 Gingival Flap Incl Rt Plan-Per Quad	198/340
2610 Inlay-Porcelain/Ceramic-One Surface	445	4249 Crn Length-Hard/Soft Tissue By Rep	232/320
2620 Inlay-Porcelain/Ceramic-Two Surfaces	445	4250 Muco-Gingival Surgery-Per Quad	232/330
2630 Inlay-Porcelain/Ceramic-Three Surfaces	445	4260 Oss Surg & Flap Ent/Clos-Per Quad	331/590
2640 Onlay-Porcelain/Ceramic-Per Tooth-Inlay	445	4268 Guid Tis Rgen Inc Sur Re-ent By Rep	320/320
2710 Crown-Resin-Laboratory	210	4270 Pedicle Soft Tissue Graft Procedure	159/375
2740 Crown-Porcelain/Ceramic Substrate	470	4271 Free Soft Tissue Graft & Donor Site	232/455
2750 Crown-Porc Fused to Hi Noble Metal	450	4320 Provisional Splinting-Intracoronal	95/116
2751 Crown-Porc Fused to Predom Base Metal	390	4321 Provisional Splinting-Extracoronal	66/120
2752 Crown-Porc Fused to Noble Metal	410	4341 Root Planing-Per Quad	60/125
2790 Crown-Full Cast High Noble Metal	455	4910 Periodontal Maintenance	40/60
2791 Crown-Full Cast Predom Base Metal	395		
2792 Crown-Full Cast Noble Metal	400	<u>ADA</u> <u>Prosthetics Removable:</u>	
2810 Crown-3/4 Cast Metallic	465	5110 Complete Uppr or Low (5120)Denture	\$495
2910 Recement Inlay	30	5120 Complete Denture Lower	495
2920 Recement Crown	30	5130 Immediate Upper or Lower (5140)Denture	495
2930 Prefab Stainlss Steel Crwn-Prim Tooth	95	5211 U Par-Acry Bs & Conv Clasps & Rests	340

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Other Benefits *continued*

PROCEDURE NAME	You Pay*	PROCEDURE NAME	You Pay*
5212 L Par-Acry Bs & Conv Clasps & Rests	\$420	<u>ADA</u> <u>Oral Surgery:</u>	
5213 U Par Bs Cst Bs W Acry Sdls & C & R	535	7286 Biopsy of Oral Tissue Soft	\$66/100
5214 L Par Bs Cst Bs W Acry Sdls & C & R	535	7291 Transseptal Fiberotomy	30/30
5281 Rm Uni Par D-I Pc-Bs Cst-Clsp-Per Unit	240	7310 Alveolopl In Conj W Extract-Per Quad	53/105
5410 Adjust Dent-Compl/Part Upper, Lower	65	7320 Alveoloplasty No Extract-Per Quad	66/120
5510 Repair Broken Compl Denture Base	50	7410 Radical Excision-Lesion to 1.25 Cm	79/150
5520 Repair Miss/Brkn T-Compl Dent EAT	40	7420 Radical Excision-Lesion over 1.25 Cm	126/225
5610 Repair Acrylic Saddle or Base	50	7430 Exc Benign Tumor-Lesion to 1.25 Cm	99/160
5620 Repair Cast Framework	55	7431 Exc Benign Tumor-Lesion Over 1.25 Cm	132/265
5630 Repair or Replace Broken Clasp	45	7450 Rem Odon & Cyst/Tum-Les to 1.25 Cm	99/160
5640 Replace Broken Teeth-Per Tooth	45	7451 Rem Odont Cyst/Tum-Les > 1.25 Cm	132/165
5650 Add Tooth to Existing Partial Denture	65	7460 Rem NonOdont Cyst/Tum-Les to 1.25 Cm	99/160
5660 Add Clasp to Existing Partial Denture	90	7461 Rem NonOdont Cyst/Tum-Les 1.25 Cm	132/265
5710 Rebase Dent-Compl/Part Upper, Lower	175	7470 Removal Exostosis-Maxilla or Mandible	172/250
5730 Reline Dent-Compl/Part-Up Lo Chairside	120	7480 Part Ostectomy Gutter or Sauceriz	265/265
5750 Reline Dent-Compl/Part-Up Lo Lab	140	<u>ADA</u> <u>Oral Surgery:</u>	
5825 Dent Temp Partial-Stayplate U/L	195	7510 I&D Abscess-Intraoral Soft Tissue	\$53/70
5850 Tissue Conditioning-Per Dent Uni	45	7520 I&D Abscess-Extraoral Soft Tissue	53/70
5851 Tissue Conditioning Lower-Denture	50	7550 Sequestrectomy for Osteomyelitis	145/145
<u>ADA</u> <u>Prosthetics Fixed:</u>		7510 I&D Abscess-Intraoral Soft Tissue	53/70
6210 Pontic-Cast High Noble Metal	\$445	7530 Rem Frn Bdy/Skn/Subcut Areo Tissue	107/160
6211 Pontic Cast Predom Base Metal	410	7910 Suture Simple Wounds up to 5 Cm	35/35
6212 Pontic-Cast Noble Metal	410	7911 Suture of Complex Wounds	70/70
6240 Pontic-Porc Fused to Hi Noble Metal	440	7960 Frenectomy Frenec/Frenot-Sep Proc	86/185
6241 Pontic-Porc Fused to Predom Base Metl	375	7970 Exc of Hyperplastic Tissue-Per Arch	53/85
6242 Pontic-Porc Fused to Noble Metal	400	7971 Excision of Pricoronal Gingiva	60/140
6520 Inlay-Metallic-Two Surfaces	315	<u>ADA</u> <u>Orthodontics:</u>	
6530 Inlay-Metallic-3 or More Surfaces	350	8440 Orthodontic Fully Banded (2Yr) Case	2375
6540 Onlay-Metallic-Per Tooth-Inlay	385	<u>ADA</u> <u>Additional Procedures:</u>	
6545 Cast Metal Retainer for Acid Etch Brdg	200	9110 Palliative Tx-Emer Treat Dent Pain-Minor	\$25
6750 Crown-Porc Fused to Hi Noble Metal	450	9220 General Anesthesia	66/165
6751 Crown-Porc Fused to Predom Base Metl	375	9221 Gen Aneth Each Add'l 15 min	33/110
6752 Crown-Porc Fused to Noble Metal	405	9230 Analgesia (Nitrous Oxide)	15/20
6780 Crown-3/4 Cast High Noble Metal	425	9240 Intravenous Sedation (Per 1/2 Hour)	44/160
6790 Crown-Full Cast Hi Noble Metal	455	9310 Consultation (Per Session)	40/44
6791 Crown-Full Cast Predom Base Metal	405	9910 Application of Desensitizing Medication	25/25
6792 Crown-Full Cast Noble Metal	415	9940 Occlusal Guards By Report	145/240
6930 Recement Bridge	35	9951 Occlusal Adjustment-Limited	33/51
<u>ADA</u> <u>Oral Surgery:</u>		9952 Occlusal Adjustment-Complete	132/218
7110 Single Tooth Extraction	\$30/45	9980 Sterilization Surcharge (Per Visit)	5/5
7120 Each Additional Tooth Extraction	25/40	9990 After Hours Surcharge	25/25
7130 Root Removal-Exposed Roots	14/35	9999 Broken Appointment Fee (Per 1/2 Hr)	15/15
7210 Surgical Removal of Erupted Tooth	33/90		
7220 Rem Impacted Tooth-Soft Tissue	46/115		
7230 Rem Impacted Tooth-Partial Bony	60/145		
7240 Rem Impacted Tooth Complete Bony	99/170		
7250 Surg Rem Resid T Roots-Cutting Proc	53/95		
7260 Oroantral Fistula Closure	152/190		
7270 Tooth Replantation	93/215		
7280 Surg Expos Imp/Unerup Tooth-Ortho	112/185		
7281 Surg Expos Imp/Unerup Tooth-Aid Erup	79/150		
7285 Biopsy of Oral Tissue Hard	66/115		

*When two copayments are listed, the amount on the left is due when service is provided by a general Dentist; the amount on the right is due when service is provided by a Specialist.

Lab fees for biopsies and excisions are to be paid by the patient.

Orthodontic benefits for ages 19 and under; adult orthodontics are not covered.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Other Benefits *continued*

There will be a \$25 surcharge for covered dental services provided after-hours and a \$15 broken appointment fee applies to each one half hour of scheduled appointment time. For a complete listing of participating Plan dentists please call the Kaiser Dental Plan in the Washington area 301/986-5600, 1-800/638-8847 in the Baltimore area or call the Plan's Member Services Department.

Accidental injury benefit

This Plan provides coverage for necessary emergency dental services directly resulting from an accidental injury. You pay nothing. Restorative services necessary to repair or replace sound natural teeth are covered when provided by participating Plan dentists. You pay nothing.

What is not covered

- Hospitalization for dental procedures, except as covered under Hospital/Extended Care Benefits-Limited benefits
- Replacement of dentures or bridge work due to loss or theft or accidental injury
- Dental procedures or services for cosmetic purposes
- Other dental services not shown as covered
- Laboratory fees for biopsies and excisions
- Fully banded orthodontics for members ages 20 and over

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, this Plan provides certain vision care benefits from Plan providers.

- Routine eye examinations, including lens prescription for eyeglasses. You pay a \$10 copayment per examination.
- Eyeglasses including frames and lenses, and the initial fitting and purchase of contact lenses. You pay all charges less 25% off the usual and customary charges on all purchases of eyeglass lenses and frames and less 15% off the usual and customary charge on the cost of the initial fitting and purchase of contact lenses. Members may apply the above discounts to purchases of lenses and frames as often as they wish.

What is not covered

- Eye exercises
- Cost of eyewear not purchased at Plan facilities

Notes

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Membership Service Office at 301/ 468-6000 in Rockville, MD or 1-800-777-7902 in the Baltimore area or you may write to the Plan at 2101 East Jefferson Street, Box 6103, Rockville, MD 20849-6103. You may also access the Plan's World Wide Web site at <http://www.kaiseronline.org>.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, DC 20044.

How to Obtain Benefits *continued*

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement—If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Changes January 1998

Do not rely on this page; it is not an official statement of benefits.

Program-wide changes:

This year, the Office of Personnel Management (OPM) instituted minimum benefit levels in all plans for normal deliveries (48 hours of inpatient care), caesarean sections (96 hours of inpatient care) and mastectomies (48 hours of inpatient care). See pages 10-19 for this Plan's benefits.

The mammography screening schedule is shown on page 10.

OPM also requires each prepaid plan to list the specific artificial insemination procedures that it covers. See page 11 for this Plan's benefits.

Changes to this Plan:

- Chiropractic services are covered up to a \$1,000 per year. See page 11.
- Hospitalization for certain dental procedures are covered. See page 12.
- Home health services for women and newborns who have been discharged from the hospital following obstetrical inpatient care are covered. See page 11.
- The copay levels for outpatient mental conditions has decreased to nothing for the 1st through 5th visits; \$10 for an individual visit and \$5 for group visits 6 through 20; and \$30 for an individual visit and \$5 for group visits for the remainder of the calendar year. See page 15.
- Inpatient mental health visits increased from 30 days to an unlimited number of days per calendar year. See page 15.
- Acute detoxification has increased from 30 days to an unlimited number of days per calendar year. See page 12.
- Prescription drugs and refills are dispensed up to a 90-day supply based upon the prescribed dosage and standard manufacturer's package size. See page 15.
- Oral contraceptives are dispensed up to a 90-day supply. See page 16.
- The charge for brand name prescription drugs has increased from \$5 per prescription or refill to \$15 per prescription or refill. See page 15.
- Erectile dysfunction drugs are covered at 50% of the average wholesale price (AWP). See page 16.
- Injectable contraceptives are dispensed with a \$7 copay. See page 16.
- The copay for ovulation stimulants has decreased from \$100 to 25% of the average wholesale price (AWP). See page 16.

Summary of Benefits for Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. - 1998

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

	Benefits	Plan pays/provides	Page
Inpatient care	Hospital	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing	12
	Extended care	All necessary services, for up to 100 days per calendar year. you pay nothing	12
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for unlimited number of days of inpatient care per calendar year. You pay nothing.	15
	Substance abuse	Inpatient rehabilitation services. You pay nothing for unlimited number of days in a hospital or specialized facility per calendar year	15
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay nothing per office visit; nothing per house call by a doctor	10-11
	Home health care	All necessary visits by nurses and health aides. You pay nothing per visit	10-11
	Mental conditions	Unlimited visits per year. You pay nothing for the first five visits, then \$10 for individual visits, \$5 for group visits 6-20; then \$30 for individual visits; \$5 for group visits for the remainder of the calendar year.	15
	Substance abuse	Outpatient counseling and treatment; you pay nothing	15
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay \$35 per emergency room visit, except for services that are not covered benefits of this Plan	13-14
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay \$7 per prescription unit or refill; you pay \$4 per prescription unit or refill obtained through the Plan's mail order program	15-16
Dental care		Accidental injury benefit; you pay nothing. Preventive dental care, comprehensive range of restorative, orthodontic, and other services. You pay copays for these service	17-18
Vision care		Refractions including lens prescription: You pay \$10 per examination. Eyeglasses including frames and lenses, and the initial fitting and purchase of contact lenses (see page 18)	19
Out-of-pocket maximum		Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for a few benefits, such as mental health outpatient visits, substance abuse inpatient rehabilitation services and prescription drugs and the copayments required for dental services	7