



A Health Maintenance Organization

This plan has full accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.



Serving: Portland and Salem, Oregon and Vancouver and Longview, Washington

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

Enrollment code:

- 571 High Option Self Only**
- 572 High Option Self and Family**
- 573 Standard Option Self Only**
- 574 Standard Option Self and Family**

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

“Visit the Plan’s Web site at <http://www.kpnw.org>”

Authorized for distribution by the:



**United States
Office of
Personnel
Management**



Federal Employees
Health Benefits Program

RI 73-004

Kaiser Foundation Health Plan of the Northwest

Kaiser Foundation Health Plan of the Northwest, 500 N. E. Multnomah St., Suite 100, Portland, Oregon 97232, has entered into a contract (CS 1047) 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 Health Plan, or 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 the inside back cover of this brochure.

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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 503/813-2000 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

General Information *continued*

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. See page 9 for information on the Medicare prepaid plan offered by this 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.

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

General Information *continued*

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 preexisting 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. Members should select a personal care doctor from among Plan primary care doctors. Services of a specialty care doctor can 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 Permanente offers comprehensive health care coverage on a prepaid group practice basis at Plan medical centers, medical offices and dental offices conveniently located throughout the Portland, Vancouver, Salem and Longview-Kelso areas, and through referral specialists, hospitals and other providers in the community. All care should be received at these facilities.

Health Plan contracts with Northwest Permanente, P.C., Physicians and Surgeons, an independent multi-specialty group of physicians, to provide or arrange all necessary physician care for Plan members. Health Plan contracts with Permanente Dental Associates, an independent group of dentists, to provide or arrange dental care for members of the High Option plan.

Medical care is provided through doctors, nurse practitioners, physician assistants and other skilled medical personnel working as medical teams. Specialists in most major specialties are available as part of the medical teams for consultation and treatment. Plan doctors also arrange for local referral specialists to provide any necessary specialty physician care not directly available from Plan doctors. Other necessary medical services, such as physical therapy and

Facts about this Plan *continued*

laboratory and X-ray services, are also available at Plan facilities. Hospital care is provided through the Plan at Kaiser Permanente Medical Centers in the Portland and Clackamas area, and at local contracting community hospitals in the Portland area, Salem and Longview. A list is available from Health Plan.

Role of a primary care doctor

The first and most important decision each member should 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 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 (generally family practitioners, pediatricians, internists, and OB/GYNs) with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Service Department at 503/813-2000. 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 facility to verify that he or she still participates in the Plan. **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.** Should you decide to enroll you will be asked to select a primary care doctor for you and each member of your family and inform your Plan facility of your selection. Members may change their doctor selection by notifying the medical office where they wish to be seen at any time.

In the event a member is receiving services from a doctor who terminates a participation agreement 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 and for certain specialty care, as shown in the Plan's Directory, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a specialist is given at the primary care doctor's discretion; if specialists or consultants are required beyond those participating in the Plan, 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, the 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 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, you must schedule an appointment so the primary care doctor can decide whether to treat the condition directly or refer you back 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

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach \$600 per Self Only enrollment or \$1,200 per Self and Family

Facts about this Plan *continued*

enrollment. This copayment maximum does not include costs of outpatient prescription drugs, dental services, outpatient mental health services beyond the first 20 covered visits, corrective appliances and artificial aids, durable medical equipment and long-term physical therapy and rehabilitation under both the High Option and Standard Option.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

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 area

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:

Oregon Area

That portion of **Oregon** within the following zip codes:

Benton County: 97330, 97331, 97333, 97339, 97353, 97370;

Clackamas County: 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97055, 97067-68, 97070, 97080, 97222, 97267-68;

Columbia County: All zip codes;

Linn County: 97321, 97335, 97355, 97358, 97374, 97389;

Marion County: 97002, 97020, 97026, 97032, 97071, 97137, 97301-3, 97305-14, 97325, 97352, 97359-60, 97362, 97373, 97375, 97381, 97383-85, 97392;

Multnomah County: All zip codes;

Polk County: All zip codes;

Washington County: 97005-8, 97062, 97075-78, 97106, 97109, 97113, 97116-17, 97119, 97123-25, 97133, 97140, 97144, 97223-25, 97229, 97291;

Yamhill County: All zip codes.

Washington Area

That portion of **Washington** within the following zip codes:

Clark County: All zip codes;

Cowlitz County: 98581, 98603, 98609, 98611, 98625-26, 98632, 98645, 98649, 98674;

Lewis County: 98591, 98593, 98596;

Wahkiakum County: 98612, 98647.

Benefits for care outside the service area are restricted to emergency care and care received at Kaiser Permanente facilities in other Kaiser Permanente Plans. See the Plan for further details on services available in other Kaiser Permanente areas.

Facts about this Plan *continued*

If you or a covered family member move outside the service area, or 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.

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

General Limitations *continued*

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.** 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 abortion 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 and outpatient surgery visits. Within the Service Area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate.

High Option

You pay a \$5 copay per visit or per doctor's house call; nothing for home visits by nurses and covered therapists. **You pay** nothing for laboratory tests and x-rays.

Standard Option

You pay an \$8 copay per visit or per doctor's house call; nothing for home visits by nurses and covered therapists. **You pay** nothing for laboratory tests and x-rays.

Medical and Surgical Benefits *continued*

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 postnatal 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. Home births are not covered.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Cornea, heart, heart-lung, kidney, kidney-pancreas, liver and lung (single and double) 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, retro peritoneal 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.
- Dialysis
- Chemotherapy, radiation therapy, and respiratory therapy
- Surgical treatment of morbid obesity
- For homebound members residing in the service area, home health services of nurses and health aides, physical or occupational therapists and speech and language pathologists, when prescribed by your Plan doctor, who will periodically review the 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.

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, including 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 months per condition if significant improvement can be expected within two months; **you pay** a \$5 copay per outpatient session under the High Option and an \$8 copay per outpatient session under the Standard Option. Speech and language services are 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.

Medical and Surgical Benefits *continued*

Specialized rehabilitation is provided on an inpatient or outpatient basis as part of a specialized multi disciplinary therapy program in a specialized facility for up to two months per condition per lifetime, when in the judgment of the Plan doctor significant improvement in function is achievable within a period of two months; **you pay** nothing.

Prosthetic devices to restore or manage head and facial structures that are defective will be provided; **you pay** a copayment equal to 20% of charges. Breast prostheses following a mastectomy are covered at no charge. Devices used primarily for cosmetic purposes that are not necessary to control or eliminate infection, pain or restore functions such as speech, swallowing or chewing are not covered. Artificial larynxes, voice machines, dentures and devices to treat temporomandibular joint conditions are not covered.

Diagnosis and treatment of infertility is covered; **you pay** a \$5 copay per outpatient session under the High Option and an \$8 copay per outpatient session under the Standard Option. **Artificial insemination** is covered (only intrauterine insemination (IUI)); **you pay** a \$5 copay per outpatient session under the High Option and an \$8 copay per outpatient session under the Standard Option; cost of donor sperm and donor eggs and services related to their procurement and storage are not covered. Fertility drugs are provided for covered infertility treatments under the Prescription Drugs Benefit. Other **assisted reproductive technology (ART)** procedures that enable a woman with otherwise untreatable infertility to become pregnant through other artificial conception procedures such as in vitro fertilization, gamete and zygote intra fallopian transfers are not covered. Infertility services are not available when either member of the family has been voluntarily surgically sterilized.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Plastic surgery primarily for cosmetic purposes
- External and internally implanted hearing aids
- All eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism.
- Cochlear and penile prosthetic devices
- Chiropractic services
- Orthopedic devices including foot orthotics
- Durable medical equipment, such as wheelchairs and hospital beds
- Long-term rehabilitative and cognitive therapy
- Collection, processing and storage of blood donated by donors designated by you or a family member. Costs associated with blood donated by you for a scheduled surgery are covered when prescribed by a Plan doctor
- Transplants not listed as covered
- Cardiac rehabilitation
- Homemaker services

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 in lieu of hospitalization. **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.

Hospital/Extended Care Benefits *continued*

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or a Plan approved hospice facility. 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.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. **You pay \$25 per trip** for ambulance transport.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

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
- Collection, processing and storage of blood donated by donors designated by you or a family member. Costs associated with blood donated by you for a scheduled surgery are covered when prescribed by a Plan doctor
- Custodial care or care in an intermediate care facility
- Homemaker services for members not enrolled in the hospice program

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 a Kaiser Permanente Medical Center in the Portland and Clackamas area or a local community hospital in Salem and Longview. Emergency services are available from the Plan 24 hours a day, seven days a week. In extreme emergencies, if you are unable to contact one of the hospitals listed above, 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, 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 a \$25 ambulance copayment required.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan facility 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.

Emergency Benefits *continued*

At Plan hospitals

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

You pay... \$25 copayment per visit plus copayments for services which would normally be rendered by the Plan, including \$25 per trip for ambulance transport. If the visit results in an inpatient admission, the copayment is waived and the office visit fee is charged.

At non-Plan hospitals

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

You pay... 50% of the first \$100 incurred in a single incident plus copayments which would have been required if the care had been rendered by the Plan including \$25 per trip for ambulance transport.

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 a \$25 ambulance copayment required.

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 care services to the extent the services would have been covered if received from Plan providers.

You pay... 50% of the first \$100 incurred in a single incident plus copayments which would have been required if the care had been rendered by the Plan including \$25 per trip for ambulance transport.

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

What is not covered

- Elective care or nonemergency 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 20.

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

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year.

High Option

You pay a \$5 copay per visit for each covered visit; 50% of charges thereafter

Standard Option

You pay a \$10 copay per visit for each covered visit; 50% of charges thereafter

Inpatient care

Up to 30 days of hospitalization each calendar year; **You pay** nothing for the first 30 days - 50% of charges thereafter.

If determined to be medically necessary by the attending Plan doctor, members hospitalized for medical (non-psychiatric) conditions will be provided all necessary inpatient psychiatric consultations. This inpatient consultant benefit is in addition to the mental conditions benefits shown on this page. **You pay** nothing - both options.

Residential/day care facility

All necessary treatment up to a maximum benefit paid by the Plan of \$4,500 every two calendar years. **You pay** 20% of charges for covered services - both options.

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. If psychiatric services are necessary, they are provided in conjunction with the mental conditions benefits shown above. In addition, the Plan provides:

Outpatient care

Dependency counseling

High Option

You pay a \$5 copay per visit

Standard Option

You pay a \$8 copay per visit

Residential/day care facility

All necessary treatment up to a maximum benefit paid by the Plan of \$3,000 every two calendar years. **You pay** 20% of charges for covered services - both options.

What is not covered

Treatment which is not authorized by a Plan doctor

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor or any licensed dentist and obtained at a Plan pharmacy. You pay the applicable charge shown below for each prescription for up to a 30 day supply or 100 dosage units for oral solids or one pint for oral liquid medications, whichever is greater. Each prescription or refill is provided on the same charge basis as the original prescription. If a greater quantity is prescribed, you pay the applicable charges shown below for each multiple of a 30-days' supply or 100 dosage units for oral solids or one pint oral liquid medications, whichever is greater. **You pay** a \$5 copay 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 Plan doctor.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Oral contraceptive drugs dispensed in 90 days' supply; **you pay** a \$5 copay per prescription per 30-day supply
- Implanted time release medications, such as Norplant. For Norplant, **you pay** a one-time copayment of \$200 per prescription. For other internally implanted time-release medications, **you pay** a one-time copayment equal to the \$5 per prescription copayment times the expected number of months the medication will be effective. 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.
- Certain antacids
- Insulin
- Diabetic supplies limited to certain glucose and acetone testing products
- Certain over-the-counter medications which are prescribed by a Plan doctor and listed on the Plan's formulary as the most appropriate treatment for a particular condition
- Prescription drugs for a dental condition as listed in the Plan's dental drug formulary
- Smoking cessation drugs and medication, including prescribed nicotine gum and patches, when used in conjunction with smoking cessation programs
- Injectable contraceptives, such as Depo-Provera. **You pay** a copayment equal to the \$5 per prescription copayment times the expected number of months the medication will be effective. For Depo-Provera **you pay** a \$15 copayment.
- Disposable needles and syringes needed to inject covered prescribed medication

You pay nothing for:

- Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU)
- Immunosuppressive drugs required after a transplant
- Internally implanted time-release medications implanted during a covered hospitalization
- Intravenous fluids and medication for home use are covered under Medical and Surgical Benefits.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available, except those listed on the Plan's formulary and prescribed by a Plan doctor
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Medical supplies such as dressings and antiseptics
- Contraceptive devices
- Drugs for the treatment of infertility
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Drugs related to non-covered infertility services
- Drugs used in weight management

Other Benefits

Dental care—High Option only

What is covered

A comprehensive range of dental services (as described below) are covered for members who have elected the High Option plan, when prescribed by Plan dentists and provided at Plan dental offices. **You pay** a \$7 copay for each office visit, including routine cleaning and fillings; 50% of charges for periodontics, endodontics, prosthetic devices, gold and/or porcelain crowns, inlays or bridge pontics, dental oral surgery; an additional copay of \$25 per visit for any emergency dental care provided after hours or on weekends at Plan dental clinics or hospitals.

- Diagnostic services and preventive care—oral examinations and X-rays, cleaning of teeth, oral prophylaxis (routine teeth cleaning), including topical application of fluoride, is covered when prescribed by a Plan dentist, but not more than two (2) visits in any twelve consecutive months; prescribed space maintainers and habit appliances
- Restorative services—fillings (including local anesthesia) stainless steel or plastic crowns
- Oral surgery—removal of teeth (including local anesthesia), minor surgical preparation of mouth for insertion of dentures, surgical treatment normally performed by a dentist for minor pathological conditions
- Periodontics—treatment of diseases of tissues supporting the teeth, including all follow-up cleaning visits
- Endodontics—root canal therapy
- Prosthetic devices—full or partial dentures, gold or porcelain crowns, inlays or bridge pontics. There will be an additional charge for the use of precious metals if a clinically acceptable, non-precious metal alternative material is available and prescribed by a Plan dentist
- Out-of-area emergency care—up to \$100 toward emergency care for relief of pain, acute infection or hemorrhage, or necessary treatment (including local anesthesia and pre-medication) due to injury
- Prescription drugs (Covered under Prescription Drug Benefits, see page 16)

Accidental injury benefit

- Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from accidental injury. **You pay** a \$7 copay for each office visit.

What is not covered

- Services received within the Service Area from non-Plan providers or at non-Plan facilities
- Orthodontics
- Treatment for problems of the jaw joint, including temporomandibular joint syndrome/craniomandibular disorders; or other conditions of the joint linking the jaw bone and skull, and of the complex of muscles, nerves and other tissues related to that joint
- Dental implants, including bone augmentation and the fixed or removable prosthetic devices attached to or covering the implants; and all services and materials relating to the placement or removal of implants including, but not limited to, diagnostic consultations, impressions, oral surgery, and cleaning; and services related to post-operative conditions or complications arising from implants
- Restorative or reconstructive services for congenital or developmental malformation
- Full mouth reconstructions
- Cosmetic dental services
- Restoration replacement. Clinically acceptable restorations or material will not be removed or replaced with alternative materials unless a pathological condition of the teeth exists
- Appliances, restorations, or procedures needed to alter vertical dimension or occlusion or for the purpose of splinting or correcting attrition or abrasion

Other Benefits *continued*

Vision care

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, this Plan provides vision care benefits to members when prescribed by Plan doctors or optometrists and provided at Plan facilities and optical departments.

What is covered

Professional services

- Refractions—**You pay** a \$5 copay per visit High Option and \$8 per visit Standard Option for eye exams for eyeglasses and contact lenses.

Eyeglasses and contact lenses—when prescribed by a Plan doctor or optometrist

- **High Option**—One pair of eyeglasses (regular lenses and designated frames), medically indicated contact lenses, or designated industrial safety glasses from the Plan's Optical Department is provided at no charge once every two years since last provided by the Plan. If a significant change in correction occurs in one or both eyes before the two years has elapsed, lenses with the new correction are provided at no charge. If you select non-medically indicated contact lenses or eyeglasses which cost more than regular lenses and designated frames, you pay charges, less a credit equal to the cost of the regular designated eyeglasses.
- **Standard Option**—You receive a credit of \$25 toward the purchase of eyeglasses, contact lenses or industrial safety glasses from the Plan's Optical Department once every two years since last provided by the Plan. The \$25 credit will apply also toward post cataract surgery benefits described below. If a significant change in correction in one or both eyes occurs before the two year period has elapsed, an additional \$25 credit will apply toward the purchase of lenses with the new correction.

Medically indicated contact lenses

Medically indicated contact lenses as described under the High/Standard Options above will be provided at no charge under the High Option and at a credit of \$25 under the Standard Option for:

- Post cataract surgery
- Extremely high degrees of near or far-sightedness
Distorted corneas which limit the best visual acuity with glasses
- Visual errors of the two eyes which are greatly different in power

Post-cataract surgery

Post-cataract surgery patients will be provided the following items at no charge under the High Option and included as part of the \$25 credit under the Standard Option:

- One pair of regular lenses and designated frames; or
- One pair of contact lenses and one pair of designated frames and reading lenses, if both must be worn at the same time to provide a significant improvement in visual acuity
- Medically necessary intra ocular lenses (at no charge for both Options)

What is not covered

- Sunglasses, prescription or plain
- Athletic safety glasses
- Photogrey, photosun, and tinted lenses
- Two pairs of lenses and frames in lieu of bifocals in the same frames
- Repair or replacement of broken, lost or stolen lenses or frames
- Contact lenses having no refractive value
- Fitting and routine follow-up services for non-medically indicated contact lenses.
- Visual training
- Refractions for non-medically indicated contact lenses
- Vision therapy (orthoptics or eye exercises)

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims procedure.

Classes to change your life style and keep you healthy

At Kaiser Permanente, we actively encourage you to share responsibility for your health care.

Choices you make every day, about what you eat and drink, whether you exercise or smoke, how you handle stress or whether you wear a seat belt, are tied directly to your health. They affect your chances of having a stroke or a heart attack, getting cancer or being at risk for handicapping injuries.

We have developed a wide range of health education and health promotion classes to help you stay healthy. You can learn how to kick the smoking habit for good, effectively manage your weight, improve personal and family relationships, deal more effectively with a chronic health problem, have a safe and healthy pregnancy, and much more. Descriptions of the *Freedom From Cigarettes* and *Freedom From Fat* classes are shown below. Over 40 other classes are also offered. Class fees begin as low as \$3 per member for some classes.

Our classes are open to everyone, but we offer them at special reduced rates to our members. If you would like to enroll, you must fill out a registration form. For the latest class catalog, call:

<i>Health education</i>	(503) 286-6816	8:00 AM - 6:00 PM, Monday - Friday
or		
<i>Customer Service</i>		
Portland area	(503) 813-2000	8:00 AM - 6:00 PM, Monday - Friday
All other areas	(800) 813-2000	8:00 AM - 8:30 PM, Monday - Friday

Freedom from Fat

A 24 week program divided into three 8 week series: I, II, III

Are you tired of losing weight just to gain it back? Do you want to learn to eat low-fat to keep your cholesterol level safe? The Freedom From Fat program can help you manage your low-fat lifestyle for good. That's because Freedom From Fat is more than a diet program. It is a new approach to eating developed by researchers at Kaiser Permanente. The three-part series of classes are conducted by professional nutrition and behavior change specialists. Each meeting provides a format for problem-solving discussion.

Note: Please complete Series I before taking Series II or III. The materials you receive in Series I will be used in both Series II and III. Series II and III, however, need not be taken in sequence.

Fees:

Series I (Eight 2 hour sessions)

Member: \$90 Additional family member: \$40 each
(does not include all materials)

General Public: \$125, Additional family member: \$75 each
(does not include all materials)

Series II (Eight 1-1/2 hours sessions)

Member: \$40 Additional family member: \$25 each
General Public: \$75, Additional family member: \$60 each

Series III (Eight 2 hour sessions)

Member: \$40 Additional family member: \$25 each
General Public: \$75, Additional family member: \$60 each

Freedom From Cigarettes

Learn the latest and most effective techniques for kicking the smoking habit for good. Sessions include:

- relaxation techniques
 - understanding cigarette addiction
 - practicing effective ways to remain a non-smoker
- Four 2-hour classes and four 1-1/2 hour classes

Fees:

Member: \$25 per person, plus \$50 deposit, refunded on completion of all classes.

General public: \$110 per person, plus \$50 deposit, refunded on completion of all classes.

Sessions from both Freedom From Cigarettes and Freedom From Fat provide a free-no obligation, 1-hour Explanatory Session (no registration needed.) Call (503) 286-6880 (message recorder) and leave your name, address and phone number. We will send you class dates, times and locations.

Medicare prepaid Plan enrollment

Federal annuitants entitled to Medicare (Parts A and B or Part B only) may have the opportunity to enroll in Federal annuitants entitled to Medicare (Parts A and B or Part B only) may have the opportunity to enroll in a special Medicare program offered by the Plan through a contract with the Health Care Financing Administration. In addition to your regular FEHBP benefits, this special Medicare program offers enhanced benefits at no additional cost to you. To learn more about this choice, call 1-800-813-2000.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-813-2000 for information on the benefits available under the Medicare HMO.

Benefits on this page are not part of the FEHB contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Service Department at 503/813-2000, or you may write to Kaiser Foundation Health Plan of the Northwest at 500 N. E. Multnomah St., Suite 100, Portland, Oregon 97232. For the hearing or speech impaired the TTY number is 800/324-8007.

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 the 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 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 explanations of benefit (JOB) 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 (CAR). 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, CAR, 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 the Kaiser Foundation Health Plan of the Northwest 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 page 11 for this Plan's benefits.

The mammogram screening schedule is shown on page 11.

OPM also requires each prepaid plan to list the specific artificial insemination procedures that it covers. See page 12 of this Plan's benefits.

Changes to this Plan

- Wheelchair car transports are no longer covered. See page 13.
- The removal and replacement of clinically acceptable restorations or material with alternative materials will not be covered as a dental benefit unless, a Plan dentist determines that removal and replacement is dentally necessary. See page 17.
- Appliances, restorations, or procedures to alter vertical dimension or occlusion or for the purpose of splinting or correcting attrition or abrasion will not be covered. See page 17.
- Two visits for oral prophylaxis, including fluoride application, are covered in any given 12-month period. See Page 17.
- Services related to dental implants and conditions or complications are not covered. See page 17.

Summary of Benefits for Kaiser Foundation Health Plan of the Northwest— High Option—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	High Option 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 up to 30 days of inpatient care per year. You pay nothing for first 30 days, 50% of charges thereafter; all necessary residential/day care treatment at a benefit maximum of \$4,500 every two calendar years. You pay 20% of charges 15
	Substance Abuse	Treatment services up to a \$3,000 benefit maximum every two calendar years. You pay 20% of charges. Mental conditions benefits are also covered as shown 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 a \$5 copay per office, outpatient surgery or doctor's home visit 10-12
	Home Health Services	All necessary visits by nurses and health aides, physical or occupational therapists and speech and language pathologists. You pay nothing 11
	Mental Conditions	Up to 20 outpatient visits per year. You pay a \$5 copay per outpatient visit; 50% of charges thereafter 15
	Substance Abuse	Short-term counseling. You pay a \$5 copay per office visit. Mental conditions benefits are also covered as shown 15
Emergency care	Reasonable charges for services and supplies required because of a medical emergency. You pay 50% of the first \$100 in charges for non-Plan for emergency care, applicable Plan copayments, and any charges for services that are not covered by this Plan 13	
Prescription drugs	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay \$5 per prescription unit or refill 16	
Dental care	Accidental injury benefit up to \$100; preventive dental care; comprehensive range of restorative, and other services. You pay a \$7 copay per office visit and 50% of charges for certain services 17	
Vision care	Covered refractions You pay a \$5 copay per visit. One pair of eyeglasses, medically necessary contact lenses, or industrial safety glasses as shown every two years. You pay nothing 18	
Out-of-pocket maximum	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of \$600 per Self Only or \$1,200 per Self and Family enrollment per calendar year, covered benefits will be provided at 100% 7	

Summary of Benefits for Kaiser Foundation Health Plan of the Northwest— Standard Option—1998

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated, subject to the definitions, 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	Standard Option pays/provides	Page
Inpatient care	Hospital	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital 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 up to 30 days of inpatient care per year. You pay nothing for first 30 days, 50% of charges thereafter; all necessary residential/day care treatment at a benefit maximum of \$4,500 every two calendar years. You pay 20% of charges 15
	Substance Abuse	Treatment services up to a \$3,000 benefit maximum every two calendar years. You pay 20% of charges. Mental conditions benefits are also covered as shown 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 an \$8 copay per office, outpatient surgery or doctor's home visit 10-12
	Home Health Services	All necessary visits by nurses and health aides, physical or occupational therapists and speech and language pathologists. You pay nothing 11
	Mental Conditions	Up to 20 outpatient visits per year. You pay a \$10 copay per outpatient visit; 50% of charges thereafter 15
	Substance Abuse	Short-term counseling. You pay an \$8 copay per office visit. Mental conditions benefits are also covered as shown 15
Emergency care	Reasonable charges for services required because of a medical emergency. You pay 50% of the first \$100 in charges for non-Plan for emergency care, applicable Plan copayments, and any charges for services that are not covered by this Plan 13	
Prescription drugs	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay \$5 per prescription unit or refill 16	
Dental care	No current benefit	
Vision care	Covered refractions. You pay an \$8 copay per visit. You receive a \$25 credit toward the purchase of a pair of eyeglasses, contact lenses, or industrial safety glasses every two years. You pay any amount above the credit 18	
Out-of-pocket maximum	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of \$600 per Self Only or \$1,200 per Self and Family enrollment per calendar year, covered benefits will be provided at 100% 7	

