

Kaiser Foundation Health Plan of Ohio

my.kp.org/federalemmployees



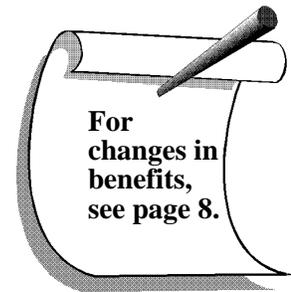
KAISER PERMANENTE®

2007

A Health Maintenance Organization (High and Standard Options)

Serving: Cleveland and Akron, Ohio Metropolitan Areas

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll or live in a contiguous county and work within our service area. See page 7 for requirements.



Enrollment codes for this Plan:

- 641 High Option Self Only
- 642 High Option Self and Family

- 644 Standard Option Self Only
- 645 Standard Option Self and Family



*This Plan has excellent accreditation from the NCQA.
See the 2007 Guide for more information on accreditation.*

Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

Important Notice from Kaiser Foundation Health Plan of Ohio About Our Prescription Drug Coverage and Medicare

OPM has determined that the Kaiser Foundation Health Plan of Ohio's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare, but you still need to follow the rules in this brochure for us to cover your prescriptions. We will only cover your prescription if it is written by a Plan provider and obtained at a Plan or affiliated pharmacy or through our direct mail service program, except in an emergency or urgent care situation.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of Kaiser Foundation Health Plan of Ohio under our contract (CS 1182) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Kaiser Foundation Health Plan of Ohio's administrative office is:

Kaiser Foundation Health Plan of Ohio
North Point Tower, Suite 1200
1001 Lakeside Avenue
Cleveland, OH 44114-1153

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 8. Rates are shown on the last page of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" or "Plan" means Kaiser Foundation Health Plan of Ohio.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOB) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 216/621-7100, or from other areas call 800/686-7100 or the TTY number at 877/676-6677 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
900 E Street NW Room 6400**

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

Exactly what will you be doing?

About how long will it take?

What will happen after surgery?

How can I expect to feel during recovery?

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, and use hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of our most recent Provider Directory. We give you a choice of enrollment in a High Option or a Standard Option Plan.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claims or pay bills. You pay only the copayments and coinsurance described in this brochure. When you receive emergency services, services covered under the travel benefit, or services related to accidental injury to teeth from non-Plan providers, you may have to submit claims.

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

General features of our High and Standard Options

How we pay providers

Kaiser Foundation Health Plan of Ohio contracts with a for-profit medical group, the Ohio Permanente Medical Group, Inc. (Medical Group), for medical services. This organization may contract with other organizations to provide services, depending upon the area in which you live. We reimburse the Medical Group for these services through an annually adjusted capitation rate. This capitation payment is paid to the Medical Group as a whole for physician services provided or arranged by the Medical Group.

We also contract with other physicians and local community hospitals. These Plan providers accept a negotiated payment from us.

Your rights

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

- Kaiser Foundation Health Plan of Ohio is a not-for-profit health maintenance organization licensed to provide prepaid health services to Ohio residents.
- This Plan is part of the Kaiser Permanente Medical Care Program, a group of not-for-profit organizations and contracting for-profit medical groups that serve over 8 million members nationwide.
- We began offering prepaid health services to members and their families in 1969.
- We presently serve nearly 150,000 members in the Cleveland and Akron metropolitan areas.
- All Kaiser Permanente and affiliated hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
- All applicants for employment with the Ohio Permanente Medical Group, Inc. must meet rigorous credentialing criteria that meet or exceed most national standards, including that of the National Committee for Quality Assurance (NCQA). Once hired, they undergo periodic review by peers and hospital boards to assure their credentials are up to date and in order.
- All Ohio Permanente Medical Group, Inc. physicians must be Board Eligible in their specialty and must become Board Certified within 5 years. At present, 96% are Board Certified.
- We credential practitioners every two years.

- If you need interpretive services during your visit, please ask an English-speaking friend or relative to call Customer Relations at 216/621-7100 or 800/686-7100.

If you want more information about us, call 216/621-7100, or from other areas call 800/686-7100 or the TTY number at 877/676-6677 or write to Customer Relations, P.O. Box 5309, Cleveland, Ohio 44114. You may also visit our Web site at my.kp.org/federalemployees.

Service Area

To enroll in this Plan, you must live in our service area. You may also live in a county contiguous to our service area as long as you work within our service area. The service area is where our providers practice.

Our service area is:

These counties in the Cleveland Metropolitan area: Cuyahoga, Geauga, Lake, Lorain, and Medina.

These counties in the Akron Metropolitan area: Portage, Stark, Summit, and Wayne.

Counties contiguous to our service area are:

Erie, Huron, Ashland, Holmes, Tuscarawas, Carroll, Columbiana, Mahoning, Trumbull, Ashtabula.

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente or allied plan service area, you can receive visiting member care from designated providers in that area. See Section 5(g), Special features, for more details. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described in Section 5(g); and for emergency care obtained from any non-Plan provider, as described in Section 5(d). We will not pay for any other health care services.

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

Section 2 How we change for 2007

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

Changes to this Plan

Changes to High Option only

- Your share of the non-Postal premium will increase by 33.3% for Self Only or 28.2% for Self and Family.

Changes to Standard Option only

- Your share of the non-Postal premium will increase by 0.1% for Self Only or no percentage change for Self and Family.
- Your prescription drug coverage will no longer include infertility drugs (see page 46).
- We decreased the primary care provider copayment to \$20; we decreased the copayment for treatment therapies, physical and occupational therapies and speech therapy to \$20; specialty care office visits will remain at \$40 per visit (see pages 18 - 44).

Changes to both High and Standard Options

- We revised the amount you pay and services that are covered when you temporarily visit another Kaiser Permanente Plan (see page 48).

Section 3 How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 216/621-7100 or 800/686-7100. You may also request replacement cards through our Web site at my.kp.org/federalemplees.

Where you get covered care

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

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We contract with the Ohio Permanente Medical Group, Inc. to provide physician services throughout the Cleveland and Akron metropolitan areas. The Ohio Permanente Medical Group, Inc. has referral relationships with other specialists within the community. You are referred to these specialists when necessary. In addition to the Ohio Permanente Medical Group, Inc., we have affiliations with physician networks throughout Northeast Ohio, sometimes referred to as affiliated physicians, to offer you greater access and choice.

We list Plan providers in the Provider Directory, which we update periodically. The list is also on our Web site: my.kp.org/federalemplees.

- **Plan facilities**

Kaiser Permanente offers comprehensive health care at Plan facilities conveniently located throughout the Cleveland and Akron metropolitan areas and through referral specialists, hospitals, and other providers in the community. Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members.

We list these facilities in the Provider Directory, which we update periodically. To get a directory, call Customer Relations at 216/621-7100 or toll-free at 800/686-7100 from anywhere within the United States. The list is also on our Web site: my.kp.org/federalemplees.

You must receive your health care services at Plan facilities, except when you have an emergency. If you are visiting another Kaiser Permanente or allied plan service area, you may receive health care services from those Kaiser Permanente facilities. See Section 5 (g), Special features, for more details. Under the circumstances specified in the brochure, you may receive follow-up or continuing care while you travel anywhere.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Choose your primary care physician from our Provider Directory. The directory lists the physicians’ addresses, phone numbers, and lets you know whether the physician is accepting new patients. To choose or change a primary care physician, call Customer Relations at 216/621-7100 or 800/686-7100. Customer Relations can help you too, by telling you who is available and sharing information about them.

- **Primary care**

Your primary care physician can be a family practitioner, internist, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may receive services for routine eye refractions from a Plan optometrist, chiropractic and acupuncture care, outpatient mental health, and outpatient alcohol and chemical dependency from a Plan provider without a referral. A woman may see her Plan obstetrician or Plan gynecologist without having to obtain a referral. While no referral is needed for obstetrical or gynecological services, you must seek this care from a specialist who is affiliated with your Primary Care Physician. Call Customer Relations to find out which OB/GYN providers are affiliated with your Primary Care Physician.

Here are some other things you should know about specialty care:

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

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

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

- **Hospital care**

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

- **If you are hospitalized when your enrollment begins**

If you are in the hospital when your enrollment in our Plan begins, call Customer Relations immediately at 216/621-7100 or 800/686-7100. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process precertification. Precertification is part of a process called Utilization Management. This process is used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. We do this to assist you in receiving appropriate covered medical care. Utilization Review takes place whether you receive your covered medical care from Plan providers, affiliated providers, or as the result of a Referral or a covered Emergency Service. As part of our Utilization Review, we use review criteria that are based on sound clinical evidence. These criteria are evaluated periodically to ensure ongoing efficacy. Qualified registered nurses and Plan providers perform utilization review. The review team ensures that clinical review criteria are consistently applied. The team also measures and evaluates the clinical appropriateness of adverse determinations that are subject to the disputed claims process. Individuals responsible for utilization management decisions do not receive any financial incentive or additional compensation for such decisions. Your physician must obtain precertification for services such as:

- Hospital admissions
- Referral to specialists
- Recommendations for follow-up care
- Skilled Nursing Care
- Surgical Procedures, such as bariatric surgery

For a complete list of services requiring preauthorization call Customer Relations at 216/621-7100 or 800/686-7100. If services are not precertified they will not be covered.

Section 4 Your cost for covered services

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

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician, you pay a copayment of \$15 per office visit (High Option plan) or \$20 per primary care office visit and \$40 per specialty care office visit (Standard Option plan).

Deductible

We do not have a deductible.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for certain services you receive.

Example: In our Plan, you pay 30% of our allowance for infertility services.

Fees when you fail to make your copayment or coinsurance

If you do not pay your copayment or coinsurance at the time you receive services, we will bill you. You will be required to pay a \$15 charge for each bill sent for unpaid services.

Note: Affiliated physician offices and other providers and facilities may bill you an additional charge along with any unpaid copayments or coinsurance.

Your catastrophic protection out-of-pocket maximum

After your copayments and coinsurance total \$2,000 per person or \$6,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. The catastrophic protection out-of-pocket maximum is the same for High Option and Standard Option. However, copayments and coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum and you must continue to pay for these services as described in this brochure.

- Outpatient prescription drugs
- Contraceptive devices
- Dental services
- Orthotic and external prosthetic devices
- Durable medical equipment
- The \$25 charges paid for follow-up or continuing care outside the service area
- Multidisciplinary services
- Services related to accidental injury to teeth
- Any non-FEHB benefits

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

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

High and Standard Option Benefits

See page 8 for how our benefits changed this year. Page 75 and page 76 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5 High and Standard Option Benefits Overview16

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Section 5 High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claims filing advice, or more information about High and Standard Option benefits, contact us at 216/621-7100 or 800/686-7100 or at our Web site at my.kp.org/federalemmployees.

Kaiser Foundation Health Plan of Ohio is on the cutting edge of high-tech solutions that improve quality of care. In 2005, Kaiser Permanente HealthConnect was implemented, improving patient scheduling, billing and registration. Kaiser Permanente HealthConnect includes the installation of a revolutionary electronic database that will provide Ohio Permanente Medical Group physicians with access to up-to-the-minute medical records for better patient care. The result will be streamlined health care delivery that is safer, efficient, and more thorough. You can come to one of our ten medical facilities located throughout Northeast Ohio, where you'll experience the convenience of receiving multiple services at one location. In most instances, you can visit your primary care physician, specialty care physician, laboratory, X-ray department and pharmacy under one roof. Kaiser Permanente is dedicated to your total health – mind, body and spirit.

In October 2003, the nonprofit National Committee for Quality Assurance (NCQA) awarded Kaiser Permanente HMO four stars in the following categories: Access and Service, Qualified Providers, Staying Healthy, Getting Better and Living with Illness. The Plan received "Excellent Accreditation" – the highest level of accreditation possible.

Today, the Health Plan offers two benefit plans to Federal members, the High and Standard Options. Both Options are designed to include preventive and acute care services provided by our Plan providers, but offer different levels of benefits and services for you to choose between to best fit your health care needs.

Each option offers unique features:

- **High Option**

Our High Option provides the most comprehensive benefits. Our FEHB High Option includes:

- \$15 per visit to your primary care physician (PCP) or a specialist for diagnostic services
- \$200 per admission on inpatient admissions
- \$75 per visit for emergency services
- \$20 visits at \$15 per visit for Chiropractic/Acupuncture visits
- \$10 per prescription or refill for covered generic drugs
- \$25 per prescription or refill for covered brand name drugs

- **Standard Option**

We also offer a Standard Option. With the Standard Option your copayments and coinsurance may be higher than for the High Option, but the bi-weekly premium is lower. Specific benefits of our FEHB Standard Option include:

- \$20 per visit to your primary care physician (PCP) or \$40 per visit to a specialist for diagnostic services
- \$500 per admission on inpatient admissions
- \$100 per visit for emergency services
- \$15 per prescription or refill for covered generic drugs
- \$30 per prescription or refill for covered brand name drugs

Please review this brochure carefully to learn which of our Kaiser Foundation Health Plan of Ohio FEHB options is best for you. If you would like more information about our benefits please contact us at 216/621-7100 or 800/686-7100 or visit our Web site: my.kp.org/federalemmployees.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • In a physician’s office • Office medical consultations • Second surgical opinions 	\$15 per office visit	\$20 per primary care office visit \$40 per specialty care office visit
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • In ambulatory surgical centers 	Nothing	Nothing
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • In an urgent care center 	\$15 per visit	\$45 per visit
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing	Nothing
<ul style="list-style-type: none"> • At home by a physician 	Nothing	Nothing
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing	Nothing

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	High Option	Standard Option
<p>Note: We cover diagnostic services related to the evaluation and treatment of infertility under our infertility services benefit.</p>	Nothing	Nothing
Preventive care, adult	High Option	Standard Option
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • A fasting lipoprotein profile (total cholesterol, LDL, HDL, and triglycerides) once every 5 years for adults 20 or over • Colorectal cancer screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 - Double contrast barium enema (DCBE) – once every five – ten years at age 50 • Routine Pap test • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older <p>Note: You should consult with your physician to determine what is appropriate for you</p> <ul style="list-style-type: none"> • Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> - Age 35 through 39, one during this five-year period - Age 40 through 64, one every calendar year - Age 65 and older, once every two consecutive calendar years • Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) <p>Note: You will still pay the office visit copay per visit for professional services of physicians and other health care professionals.</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <p><i>Physical exams required for:</i></p> <ul style="list-style-type: none"> • <i>Obtaining or continuing employment</i> • <i>Insurance</i> • <i>Governmental licensing.</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
	High Option	Standard Option
Preventive care, children		
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics <p>Note: You will still pay the office visit copay per visit for professional services of physicians and other health care professionals.</p>	Nothing	Nothing
<ul style="list-style-type: none"> Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) Well-child care including routine examinations and immunizations 	\$15 per office visit	\$20 per primary care office visit \$40 per specialty care office visit
Maternity care		
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care <p>Note: We will waive your copayment for prenatal care.</p> <p>Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your normal delivery. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your inpatient stay will be extended if medically necessary. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)). We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We cover other care of an eligible infant who requires non-routine treatment for the first 31 days. The infant will only be covered beyond the 31 days if the infant is enrolled under a Self and Family enrollment. 	\$15 per office visit Nothing for professional delivery services provided by Plan providers	\$20 per primary care office visit \$40 per specialty care office visit Nothing for professional delivery services provided by Plan providers
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Routine sonograms to determine fetal age, size or sex.</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
	High Option	Standard Option
Family planning		
<ul style="list-style-type: none"> Voluntary sterilization (See Section 5(b) Surgical procedures) Family planning services Genetic counseling <p>Note: We cover surgically implanted contraceptives, injectable contraceptive drugs, intrauterine devices (IUDs), and diaphragms under your prescription drug benefit.</p>	\$15 per office visit	\$20 per primary care office visit \$40 per specialty care office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Reversal of voluntary surgical sterilization 	<i>All charges.</i>	<i>All charges.</i>
Infertility services	High Option	Standard Option
Diagnosis and treatment of infertility such as: <ul style="list-style-type: none"> Artificial insemination by intrauterine insemination (IUI) Lab and X-ray procedures for the evaluation and treatment of involuntary infertility 	30% of our allowance per outpatient visit Nothing for inpatient	30% of our allowance per outpatient visit Nothing for inpatient
<ul style="list-style-type: none"> Infertility drugs administered in the office <p>Note: See Section 5(f) for more information on coverage of oral and injectable infertility drugs under your prescription drug benefit.</p>	30% of our allowance	30% of our allowance
<p><i>Not covered:</i></p> <p><i>These exclusions apply to fertile as well as infertile individuals or couples:</i></p> <ul style="list-style-type: none"> Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> In vitro fertilization Embryo transfer and gamete intra-fallopian transfer (GIFT) Services and supplies related to excluded ART procedures Intravaginal insemination (IVI) Intracervical insemination (ICI) Ovum transplants Zygote intrafallopian transfer (ZIFT) Services and supplies related to excluded services Procurement and storage of donor eggs and semen Procedures for women who have evidence of ovarian failure Procedures when either member of the family has been voluntarily surgically sterilized 	<i>All charges.</i>	<i>All charges.</i>

Infertility services - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Infertility services (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Services for surrogate mothers who are not Plan members Services related to surrogate arrangements. 	All charges.	All charges.
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> Testing and treatment Allergy injections 	\$15 per office visit	\$20 per primary care office visit \$40 per specialty care office visit
Allergy serum	Nothing	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> Sublingual allergy desensitization 	All charges.	All charges.
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> Chemotherapy Radiation therapy Dialysis – Hemodialysis and peritoneal dialysis at approved facilities Growth hormone therapy <p>Note: Drugs for growth hormone therapy (GHT) are covered under our prescription drug benefit. We cover home health dialysis under our home health services benefit.</p>	\$15 per office visit	\$20 per office visit
<ul style="list-style-type: none"> Respiration and inhalation therapy 	Nothing	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> Chemotherapy supported by a bone marrow transplant or with stem cell support for any diagnosis not listed as covered in Section 5(b) under Organ/tissue transplants. 	All charges.	All charges.
Physical and occupational therapies	High Option	Standard Option
<p>We cover two consecutive months or 20 visits, whichever is greater, per condition for:</p> <ul style="list-style-type: none"> Physical therapy by qualified physical therapists to restore bodily function when you have a total or partial loss of bodily function due to illness or injury Occupational therapy by occupational therapists to assist you in achieving self-care and improved functioning in other activities of daily life 	\$15 per outpatient visit Nothing for inpatient	\$20 per outpatient visit Nothing for inpatient

Physical and occupational therapies - continued on next page

Benefit Description	You pay	
Physical and occupational therapies (cont.)	High Option	Standard Option
<p>Multidisciplinary rehabilitation facility services are provided up to two months per condition. Outpatient rehabilitation, including diagnostic and restorative services, provides a program of physical, speech, occupational, respiratory therapy, social and psychological services, and other items and services that are medically necessary for rehabilitation. The two month limit applies to all inpatient and outpatient comprehensive rehabilitation services you may receive for the same condition</p>	<p>\$15 per outpatient visit Nothing for inpatient</p>	<p>\$20 per outpatient visit Nothing for inpatient</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Cognitive rehabilitative therapy</i> • <i>Cardiac rehabilitation.</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Speech therapy	High Option	Standard Option
<p>We cover two consecutive months or 20 visits, whichever is greater, per condition for:</p> <ul style="list-style-type: none"> • Speech therapy by speech therapists when medically necessary 	<p>\$15 per outpatient visit Nothing for inpatient</p>	<p>\$20 per outpatient visit Nothing for inpatient</p>
<p><i>Not covered:</i></p> <p><i>Speech therapy that is not medically necessary such as:</i></p> <ul style="list-style-type: none"> • <i>Therapy for educational placement or other educational purposes</i> • <i>Training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation</i> • <i>Therapy for tongue thrust in the absence of swallowing problems.</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<p>Hearing tests to determine the need for hearing correction</p>	<p>\$15 per office visit</p>	<p>\$20 per primary care office visit \$40 per specialty care office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, including testing and examinations for them.</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay	
	High Option	Standard Option
Vision services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> • Diagnosis and treatment of diseases of the eye • Eye refractions 	\$15 per office visit	\$20 per primary care office visit \$40 per specialty care office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • Corrective eyeglass lenses and frames • Contact lenses • Examinations for contact lenses and the fitting of contact lenses • Refractions for contact lenses • Eye surgery solely for the purpose of correcting refractive defects of the eye • Eye exercise and orthoptics. 	<i>All charges.</i>	<i>All charges.</i>
Foot care	High Option	Standard Option
<ul style="list-style-type: none"> • Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes 	\$15 per office visit	\$20 per primary care office visit \$40 per specialty care office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above • Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<i>All charges.</i>	<i>All charges.</i>
Orthopedic and prosthetic devices	High Option	Standard Option
Internal prosthetic devices, such as: <ul style="list-style-type: none"> • Pacemakers • Artificial joints • Surgically implanted breast implant following mastectomy • Intraocular lenses following cataract removal or congenital absence of the organic lens of the eye 	Nothing	Nothing
External prosthetic and orthotic devices and braces are provided under Plan criteria such as: <ul style="list-style-type: none"> • Breast prostheses and surgical bras, including necessary replacements, following a mastectomy 	20% of our allowance	20% of our allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Orthopedic and prosthetic devices (cont.)		
<ul style="list-style-type: none"> Lenses with frames or contact lenses following cataract removal or congenital absence of the organic lens of the eye Artificial limbs Terminal devices Braces Appliances essential to the effective use of artificial limbs or braces External cardiac pacemakers Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome 	20% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Comfort, convenience, or luxury equipment or features</i> <i>Corrective shoes</i> <i>Arch supports</i> <i>Foot orthotics</i> <i>Corsets, elastic stockings, garter belts, and other nonrigid appliances</i> <i>Replacement or repair of prosthetic or orthotic appliances because of misuse</i> <i>Educational training in the use of the prosthetic devices and orthotic appliances</i> <i>Prosthetics related to the treatment of sexual dysfunction.</i> 	<i>All charges.</i>	<i>All charges.</i>
Durable medical equipment (DME)		
<p>Rental or purchase, at our option, of durable medical equipment provided under our criteria as of January 1, 2006, is covered when used in your home (more than once), would not be of use to you if you were not ill or injured, and when prescribed by your Plan physician. Under this benefit, we cover:</p> <ul style="list-style-type: none"> Hospital beds Oxygen Wheelchairs Crutches Walkers Blood glucose monitors Commodes <p>Note: We cover repair and replacement not caused by misuse.</p>	20% of our allowance	20% of our allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Deluxe equipment such as motor driven wheelchairs and beds, except when such deluxe features are necessary for the effective treatment of your condition and required in order for you to operate the equipment</i> • <i>Comfort, convenience, or luxury equipment or features</i> • <i>Physicians' equipment</i> • <i>Exercise and hygienic equipment</i> • <i>Self help devices that are not medical in nature such as sauna baths or elevators</i> • <i>Experimental or research equipment</i> • <i>Replacement or repair that is needed due to misuse</i> • <i>Devices, equipment and supplies related to the treatment of sexual dysfunction</i> • <i>Electronic monitors of the heart or lungs (except apnea monitors for newborns)</i> • <i>Devices to perform medical tests on blood or other bodily substances or excretions (except blood glucose monitors for insulin dependent diabetics).</i> <p><i>Note: Rental items which are no longer medically necessary must be paid for or returned.</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Home health services	High Option	Standard Option
<p>If you are homebound and reside within the service area:</p> <ul style="list-style-type: none"> • You may receive home health care ordered by a Plan physician and provided by a registered nurse, practical nurse, licensed vocational nurse, or home health aide • Services include oxygen therapy, intravenous therapy and medications • Home dialysis <ul style="list-style-type: none"> - Hemodialysis - Intermittent peritoneal dialysis - Continuous ambulatory peritoneal dialysis • Intravenous (IV)/ Infusion Therapy <p>Note: The services are covered only if a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home.</p>	<p>Nothing</p>	<p>Nothing</p>
<p><i>Not covered:</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Home health services - continued on next page

Benefit Description	You pay	
Home health services (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> • <i>Services outside the service area</i> • <i>Home health care that a Plan provider determines may be appropriately provided in a Plan facility or other facility we designate and we provide, or offer to provide, that care in one of these facilities.</i> 	<i>All charges.</i>	<i>All charges.</i>
Chiropractic	High Option	Standard Option
<p>You may receive up to 20 visits for chiropractic and acupuncture services. The total visit limit is 20 for any combination of chiropractic or acupuncture services. For a description of the acupuncture benefit see Alternative treatments in this section.</p> <p>Chiropractic services are provided through American Specialty Health Network (ASHN). You will have direct access to a participating ASHN chiropractor without the need to obtain a Plan physician referral. Participating chiropractors are listed in the ASHN Participating Provider Directory. For a copy of the most recent directory call: 800/678-9133.</p> <p>You may phone the ASHN chiropractor you have selected for an initial examination. After the initial examination, your ASHN chiropractor is responsible for obtaining authorization from ASHN for any additional chiropractic services on your behalf.</p> <p>You may receive 20 visits for chiropractic services (in combination with acupuncture services) for the treatment of neuromusculoskeletal disorders. Services include:</p> <ul style="list-style-type: none"> • Examinations • Adjunctive chiropractic therapy such as ultrasound, hot packs, cold packs, and electrical stimulation • Plain film X-rays and laboratory tests • Up to \$50 for chiropractic appliances 	\$15 per office visit	Not covered
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Any service that is not authorized or delivered by participating providers</i> • <i>Hypnotherapy, behavior training, sleep therapy, and weight programs</i> • <i>Thermography</i> 	<i>All charges.</i>	<i>All charges.</i>

Chiropractic - continued on next page

Benefit Description	You pay	
Chiropractic (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Any radiologic exam other than plain film studies such as magnetic resonance imaging, CAT scans, bone scans, nuclear radiology Education programs, non-medical self-care or self-help or any self-help physical exercise training or any related diagnostic testing Services or treatments for pre-employment physicals or vocational rehabilitation Adjunctive therapy not associated with spinal, muscle or joint manipulation. 	All charges.	All charges.
Alternative treatments	High Option	Standard Option
<ul style="list-style-type: none"> Biofeedback when administered by our Mental Health Department as part of a prescribed pain management program or a treatment plan for other physical symptoms which are not responsive to the usual medical treatment methods <p>You may receive up to 20 visits for acupuncture and chiropractic services. The total visit limit is 20 for any combination of acupuncture or chiropractic services. For a description of the chiropractic benefit see Chiropractic in this section.</p> <p>Acupuncture services are provided through American Specialty Health Network (ASHN). You will have direct access to a participating ASHN acupuncturist without the need to obtain a Plan physician referral. Participating acupuncturists are listed in the ASHN Participating Provider Directory. For a copy of the most recent directory call: 800/678-9133.</p> <p>You may phone the ASHN acupuncturist you have selected for an initial examination. After the initial examination, your ASHN acupuncturist is responsible for obtaining authorization from ASHN for any additional acupuncture services on your behalf.</p> <p>You may receive 20 visits for acupuncture services (in combination with chiropractic services) for the treatment of neuromusculoskeletal disorders, nausea, or pain syndromes. Services include:</p> <ul style="list-style-type: none"> Examinations Adjunctive acupuncture therapy such as acupressure, moxibustion, and cupping Plain film X-rays and laboratory tests 	\$15 per office visit	\$40 per office visit
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>

Alternative treatments - continued on next page

Benefit Description	You pay	
Alternative treatments (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Any service that is not authorized or delivered by participating providers • Hypnotherapy, behavior training, sleep therapy, and weight programs • Thermography • Any radiologic exam other than plain film studies such as magnetic resonance imaging, CAT scans, bone scans, nuclear radiology • Education programs, non-medical self-care or self-help or any self-help physical exercise training or any related diagnostic testing • Services or treatments for pre-employment physicals or vocational rehabilitation • Adjunctive therapy not associated with acupuncture • All other forms of alternative treatment. 	<i>All charges.</i>	<i>All charges.</i>
Educational classes and programs	High Option	Standard Option
<p>Health education for conditions such as diabetes, post-coronary, and nutritional counseling.</p>	\$15 per office visit	<p>\$20 per primary care office visit</p> <p>\$40 per specialty care office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other educational programs and materials. 	<i>All charges.</i>	<i>All charges.</i>

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay	
	High Option	Standard Option
Surgical procedures		
A comprehensive range of services, such as:	\$15 per office visit for outpatient services	\$20 per primary care office visit for outpatient services
<ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Pre-surgical testing • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Surgical treatment of morbid obesity (bariatric surgery) – You must be at least 18 years of age or older and have either (1) a body mass index (BMI) of at least 40 or (2) a BMI greater than 35 but less than 40 when a combination of at least two of the following severe or life threatening conditions are also present: <ul style="list-style-type: none"> - Diabetes - Hypertension - Hypertriglyceridemia - Obstructive sleep apnea - Cardiomyopathy related to obesity - Severe GERD 	Nothing for inpatient services	\$40 per specialty care office visit for outpatient services
		Nothing for inpatient services

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Degenerative disease of weight bearing joints of enough significance to warrant surgical replacement - Pseudotumor cerebri <p>Note: You will need to meet the above qualifications before your Plan provider will refer you to our bariatric surgery program. This program may refer you to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including nutritional, psychological, medical and social readiness for surgery. Final approval for surgical treatment will be required from the Ohio Permanente Medical Group’s designated physician. See services requiring our prior approval in Section 3.</p> <ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs). Note: Devices and drugs are covered under Section 5(f). • Other implanted time-release drugs • Treatment of burns 	<p>\$15 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$20 per primary care office visit for outpatient services</p> <p>\$40 per specialty care office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine foot care</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Reconstructive surgery	High Option	Standard Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance; and - the condition can reasonably be expected to be corrected by such surgery • Surgery for treatment of a form of congenital hemangioma known as port wine stains on the face of members 18 years or younger • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance on the other breast; - treatment of any physical complications, such as lymphedemas; and 	<p>\$15 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$40 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$15 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$40 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except as otherwise specified above</i> • <i>Surgeries related to sex transformation.</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Oral and maxillofacial surgery	High Option	Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and tumors; • Medical and surgical treatment of TMJ (non-dental); • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$15 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$40 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Correction of malocclusion</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone), except for procedures related to accidental injury of teeth</i> • <i>Dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i> • <i>Dental services associated with medical treatment such as surgery and radiation treatment, except for services related to accidental injury of teeth</i> • <i>Oral implants and transplants.</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay	
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ tissue transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney/Pancreas • Liver • Lung: Single - Double • Pancreas 	<p>\$15 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$40 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the diagnosis and staging description).</p> <ul style="list-style-type: none"> • Allogeneic transplants <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	<p>\$15 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$40 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogenic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma 	<p>\$15 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$40 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors <p>Limited Benefits – Autologous blood or bone marrow stem cell transplants for breast cancer and epithelial ovarian cancer may be provided in a National Cancer Institute (NCI) – or National Institutes of Health (NIH) – approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p>	<p>\$15 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$40 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial or non-human organs • Transplants not listed as covered 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	<p>Nothing</p>	<p>Nothing</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Office 	<p>\$15 per office visit</p>	<p>\$20 per primary care office visit</p> <p>\$40 per specialty care office visit</p>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS (except for Maternity stays).** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
	High Option	Standard Option
<p>Inpatient hospital</p> <p>Room and board, such as:</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>Notes:</p> <ul style="list-style-type: none"> • Separate copayments for inpatient hospital stays, if any, apply to the mother and the newborn. • If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. 	\$200 per admission	\$500 per admission
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood and blood products • Dressings, splints, plaster casts, and sterile tray services • Medical supplies, appliances, and equipment, including oxygen • Anesthetics, including nurse anesthetist services • The collection and storage of autologous blood for elective surgery when authorized by a Plan physician. 	Nothing	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	High Option	Standard Option
<p>Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The need for anesthesia, by itself, is not such a condition.</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care and care in an intermediate care facility • Non-covered facilities, such as nursing homes • Personal comfort items, such as telephone, television, barber services, and guest meals and beds • Private nursing care, except when medically necessary • Inpatient dental procedures • Cord blood procurement and storage for possible future need for a yet-to-be determined member recipient. 	<i>All charges.</i>	<i>All charges.</i>
Outpatient hospital or ambulatory surgical center	High Option	Standard Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Dressings, casts , and sterile trays • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood and blood products • The collection and storage of autologous blood for elective surgery when authorized by a Plan physician • Pre-surgical testing • Medical supplies, including oxygen • Anesthetics and anesthesia service 	\$15 per outpatient surgery	\$250 per outpatient surgery
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient. 	<i>All charges.</i>	<i>All charges.</i>
Skilled nursing care facility benefits	High Option	Standard Option
<p>Up to 100 days per calendar year</p> <ul style="list-style-type: none"> • When you need full-time skilled nursing care <p>All necessary services are covered including:</p> <ul style="list-style-type: none"> • Room and board • General nursing care • Medical social services 	Nothing	Nothing

Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Skilled nursing care facility benefits (cont.)		
<ul style="list-style-type: none"> • Prescribed drugs, biologicals, supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care and care in an intermediate care facility</i> • <i>Personal comfort items, such as telephone, television, barber services, and guest meals and beds.</i> 	<i>All charges.</i>	<i>All charges.</i>
Hospice care	High Option	Standard Option
<p>Supportive and palliative care is provided for a terminally ill member with a life expectancy of less than six months when:</p> <ul style="list-style-type: none"> • You reside in the service area; and • Services are provided in the home; or • Services are provided in a Plan-approved hospice facility <p>Services include inpatient care, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less.</p> <p>Notes:</p> <ul style="list-style-type: none"> • Hospice is a program for caring for the terminally ill that emphasizes supportive services, such as home care and pain control, rather than curative care of the terminal illness. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, physician services, and short-term inpatient care for pain control and acute and chronic symptom management. We also provide counseling and bereavement services for the individual and family members, and therapy for purposes of symptom control to enable the person to continue life with as little disruption as possible. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered. • The services are covered only if a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home. 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Private duty nursing (independent nursing)</i> • <i>Homemaker services.</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
Ambulance	High Option	Standard Option
<ul style="list-style-type: none"> • Local licensed ambulance service when medically necessary • See Section 5(d) for emergency services 	\$50 per trip	\$100 per trip
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider</i> 	<i>All charges.</i>	<i>All charges.</i>

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In a life-threatening emergency, call 911 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 us. You or a family member must notify us within 24 hours unless it is not reasonable to do so. It is your responsibility to be sure we have been timely notified.

Emergencies within our service area:

Emergency care may be received by calling 911 or by going to the nearest emergency room.

If you are unsure whether you are experiencing an emergency, call your Primary Care Physician at the number listed in the Provider Directory, or if you have selected an Ohio Permanente Group Physician as your Primary Care Physician, call our 24-hour Advice Line at 216/445-4900 or 800/686-2240 (216/398-3187 – TTY for the hearing/speech impaired) for assistance. If you have selected an affiliated physician as your Primary Care Physician, call that office for assistance. Refer to the Provider Directory for the number of your physician's office. To better coordinate your emergency care, if you are inside the Service Area, you should go to a Plan facility if possible. You must return to us for follow-up care after emergency services are received within our service area.

If you need to be hospitalized at a non-Plan facility, we must be notified within 24 hours or as soon as reasonably possible. You can call us toll-free from anywhere in the United States at 877/676-6270. If you are hospitalized in a non-Plan facility and our physicians believe care can be better provided in a Plan designated hospital, you will be transferred when medically feasible. If you do not notify us, we will not cover any services you receive after transfer would have been possible. Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching us would result in death, disability, or significant jeopardy to your condition.

Emergencies outside our service area:

Emergency care may be received by calling 911, by going to the nearest emergency room or seeking care at any urgent care or physician's office for medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, you must notify us within 24 hours or as soon as is reasonably possible. You can call us toll-free from anywhere in the United States at 877/676-6270. If a Plan physician believes care can be better provided in a Plan hospital, we will transfer you when medically feasible. Payment is limited to Emergency Services required before your medical condition permits your travel or transfer to a Plan Facility.

You may obtain emergency and urgent care from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local telephone book under “Kaiser Permanente.” You may also call Customer Relations at 800/686-7100. See Travel benefit Section 5(g) for follow up care received outside the service area.

Benefit Description	You pay	
	High Option	Standard Option
Emergency within our service area	High Option	Standard Option
Emergency care as an outpatient, including physicians' services <ul style="list-style-type: none"> • At a physician's office 	\$15 per office visit	\$20 per primary care office visit \$40 per specialty care office visit
<ul style="list-style-type: none"> • At a Plan urgent care center 	\$15 per visit	\$45 per visit
<ul style="list-style-type: none"> • In a hospital emergency room <p>Note: We waive your copayment if you are admitted to a hospital as an inpatient. Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency copayment will not be waived.</p>	\$75 per visit	\$100 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care.</i> 	<i>All charges.</i>	<i>All charges.</i>
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> • At a physician's office 	\$15 per office visit	\$20 per primary care office visit \$40 per specialty care office visit
<ul style="list-style-type: none"> • At an urgent care center 	\$15 per visit	\$45 per visit
<ul style="list-style-type: none"> • In a hospital emergency room 	\$75 per visit	\$100 per visit
<p>Notes:</p> <ul style="list-style-type: none"> • See the Travel benefit in Section 5(g) for coverage of continuing or follow-up care. • We waive your copayment if you are admitted to a hospital as an inpatient. Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency copayment will not be waived. 		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
Ambulance	High Option	Standard Option
Professional ambulance, air or ground service, when medically necessary. Note: See Section 5(c) for non-emergency service.	\$50 per trip	\$100 per trip
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Ambulance service that does not meet our criteria for transport.</i> 	<i>All charges.</i>	<i>All charges.</i>

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are clinically appropriate to treat your condition.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
	High Option	Standard Option
<p>Mental health and substance abuse benefits</p> <p>We cover all diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Notes:</p> <ul style="list-style-type: none"> • We cover the services only when we determine that the care is clinically appropriate to treat your condition, and only when you receive the care as part of a treatment plan developed by a Plan provider. • OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment in favor of another. 	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions</p>
<p>Diagnosis and treatment of psychiatric conditions for children, adolescents, and adults. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Treatment and counseling (including individual and group therapy visits) • Crisis intervention and stabilization for acute episodes • Psychological testing necessary to determine the appropriate psychiatric treatment 	<p>\$15 per office visit for individual therapy</p> <p>\$7 per office visit for group therapy</p>	<p>\$40 per office visit for individual therapy</p> <p>\$20 per office visit for group therapy</p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<p>Diagnosis and treatment of alcoholism and drug abuse. Services include:</p> <ul style="list-style-type: none"> • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) <p>Notes:</p> <ul style="list-style-type: none"> • You may see an outpatient mental health or substance abuse provider without a referral from your primary care physician. • Your mental health or substance abuse provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you. 	<p>\$15 per office visit for individual therapy</p> <p>\$5 per office visit for group therapy (maximum \$5 per day for substance abuse benefit)</p>	<p>\$40 per office visit for individual therapy</p> <p>\$5 per office visit for group therapy (maximum \$5 per day for substance abuse benefit)</p>
<ul style="list-style-type: none"> • Medication evaluation and management 	<p>\$15 per office visit for individual therapy</p>	<p>\$40 per office visit for individual therapy</p>
<ul style="list-style-type: none"> • Inpatient psychiatric or substance abuse care • Hospital alternative services, such as partial hospitalization, day and night care <p>Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan physician.</p>	<p>\$200 per admission</p>	<p>\$500 per admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Care that is not clinically appropriate for the treatment of your condition</i> • <i>Services we have not approved</i> • <i>Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of psychiatric condition</i> • <i>Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate</i> • <i>Services that are custodial in nature</i> • <i>Services rendered or billed by a school or a member of its staff</i> • <i>Services provided under a federal, state, or local government program</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms.</i> 	<i>All charges.</i>	<i>All charges.</i>
Limitation	We may limit your benefits if you do not obtain a treatment plan.	

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart in this section.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **If you have questions** about your prescription drug benefits, please contact Customer Relations at 216/621-7100 or 800/686-7100.
- **Who can write your prescription.** A licensed health care professional authorized to prescribe drugs must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan or affiliated pharmacy or through our direct mail service. You may order refills by phone, in person or by using our member Web site: my.kp.org/federalemployees. If you use our online service you can choose to pick up your order at a Plan operated pharmacy or have the order mailed to your home. Online prescription orders mailed to your home must be paid in advance using a credit card. With the exception of insulin, certain medications, such as those requiring refrigeration and certain controlled medications, are not available through direct mail.
- **We use a formulary.** Your Kaiser Permanente prescription drug benefit uses a formulary. A formulary is a list of medications your physician can choose from that will be covered under your prescription drug benefit. The medications included in the Kaiser Permanente Drug Formulary are chosen by a group of Kaiser Permanente physicians, pharmacists, and nurses known as the Pharmacy and Therapeutics Committee. This Committee meets regularly to evaluate and choose those medications that are most effective, safe, and useful in caring for our members. Kaiser Permanente doctors and other providers use the Formulary to guide their decisions when they need to prescribe drugs. Non-formulary drugs will be covered when the drug is medically necessary. If you request a non-formulary drug when your physician believes the formulary alternative is effective, the non-formulary drug is not covered. You may purchase non-formulary drugs from a Plan or affiliated pharmacy at prices charged to members for non-covered drugs.
- **These are the dispensing limitations.** Prescription drugs will be provided up to a 31-day supply or 62-day supply sent to your home through our direct mail service. We provide up to a 31-day supply based upon (a) the prescribed dosage, (b) the standard manufacturer's package size, and (c) specified dispensing limits. If you ask for a mail order prescription too soon after the last one was filled, the mail order pharmacy staff will send you a letter telling you it was too soon to fill the prescription. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call their Plan pharmacy for assistance.
- **Why use generic drugs?** Brand-name drugs are drugs that are produced and sold under the original manufacturer's brand name. Generic drugs are produced and sold under their chemical names after the patent of the brand-name drug expires. Under federal law, generic and brand-name drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your plan less money than a brand-name drug.
- **When do you have to file a claim?** For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy. You do not have to file a claim when you receive drugs from a Plan or affiliated pharmacy (including drugs received through our direct mail service).

Benefit Description	You pay	
Covered medications and supplies	High Option	Standard Option
<p>We cover the following medications and supplies:</p> <ul style="list-style-type: none"> • Drugs for which a prescription is required by law • Oral contraceptives and diaphragms • Insulin • Disposable needles and syringes for the administration of insulin • Growth hormones • Prescription smoking cessation drugs when you participate in and pay the cost of a Plan approved smoking cessation class. See Section 5(i) for health education classes. The drug must be prescribed by a Plan physician with prior authorization from the Plan. Coverage is limited to one course of therapy per year. • Compounded drugs <p>Notes:</p> <ul style="list-style-type: none"> • The brand name drug copayment applies to compounded products and to single source generic drugs. • A compounded drug is one in which two or more drugs or pharmaceutical agents are combined together to meet the requirements of a prescription. • A single source generic drug is a generic drug available in the United States only from a single manufacturer and that is not listed as generic in the then-current commercially available drug databases to which the Plan subscribes. 	<p>\$10 per prescription or refill for generic drugs</p> <p>\$25 per prescription or refill for brand-name drugs or compounded drugs</p>	<p>\$15 per prescription or refill for generic drugs</p> <p>\$30 per prescription or refill for brand-name drugs or compounded drugs</p>
<ul style="list-style-type: none"> • Contraceptive devices, implanted time-release contraceptive drugs, topical contraceptives and injectable contraceptives <p>Note: We do not refund any portion of the copayment if you request removal of the contraceptive or the contraceptive is no longer in use for any reason before the end of its expected life.</p>	<p>A one-time payment equal to \$10 times the expected number of months the generic medication will be effective, not to exceed \$200</p> <p>A one-time payment equal to \$25 times the expected number of months the brand-name medication will be effective, not to exceed \$200</p>	<p>A one-time payment equal to \$15 times the expected number of months the generic medication will be effective, not to exceed \$200</p> <p>A one-time payment equal to \$30 times the expected number of months the brand-name medication will be effective, not to exceed \$200</p>
<ul style="list-style-type: none"> • Infertility drugs 	<p>50% of our allowance</p>	<p><i>All charges.</i></p>
<ul style="list-style-type: none"> • Drugs for sexual dysfunction <p>Note: Certain drugs to treat sexual dysfunction have dispensing limits. Contact us for details.</p>	<p>50% of our allowance</p>	<p>50% of our allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Vitamins and nutritional supplements that can be purchased without a prescription</i> • <i>Nonprescription drugs including over the counter nicotine replacement products</i> • <i>Non-formulary nicotine replacement products</i> • <i>Prescriptions filled at non-Plan pharmacies, except for out-of-area emergencies</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs used to shorten the duration of the common cold</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs for non-covered services</i> • <i>Drugs for the purpose of weight loss</i> • <i>Drugs and materials that require administration by medical personnel or observation by medical personnel during or after administration</i> • <i>Replacement of lost or damaged prescriptions</i> • <i>Benzoyl peroxide products</i> • <i>Special medication packaging other than the Plan's standard packaging is excluded unless required by law.</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Section 5(g) Special features

Feature	Description
24 hour advice line	<p>If you have selected an Ohio Permanente Group physician as your primary care physician, you may call 800/686-2240 (TTY 216/398-3187 or 877/398-3187) 24 hours a day, 7 days a week. You may talk with a registered nurse who can help assess medical symptoms for any of your health concerns and provide advice over the phone, when medically appropriate. If you have selected an affiliated physician as your primary care physician, call that office for assistance. Refer to the Provider Directory for the number of your physician’s office.</p>
Centers of excellence	<p>Kaiser Permanente, nationally, has a National Transplant Network that contracts with transplant centers that meet our requirements for excellence.</p> <p>The Centers of Excellence program began in Fall 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted “Centers of Excellence” for certain specialized medical procedures.</p> <p>We have developed a network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.</p>
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other treatments as a less costly alternative benefit. • We review alternative treatments on an ongoing basis. • By approving an alternative treatment, we cannot guarantee you will get it in the future. • The decision to offer an alternative treatment is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative treatments is not subject to OPM review under the disputed claims process.
Services from other Kaiser Permanente Plans	<p>When you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered services, copayments and coinsurance described in this FEHB brochure. The 90 day limit on visiting member care does not apply to a Dependent child who attends an accredited college or accredited vocational school.</p> <p>Please call Customer Relations at 216/621-7100 or toll-free at 800/686-7100 to receive more information about visiting member care, including facility locations in other service areas. Service areas and facilities where you may obtain visiting member care may change at any time.</p>

Feature - continued on next page

Feature	Description
Feature (cont.)	Description
<p>Travel benefit</p>	<p>Kaiser Permanente’s travel benefits for Federal employees provide you with outpatient follow-up or continuing medical care when you are temporarily outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency and urgent care benefits and include:</p> <ul style="list-style-type: none"> • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast. • Outpatient continuing care for covered services for conditions diagnosed and treated within the previous 90 days by a Kaiser Permanente health care provider or affiliated Plan provider. Services include dialysis and prescription drug monitoring. • You pay \$25 for each follow-up or continuing care visit. We deduct this amount from the payment we make to you. • We pay no more than \$1,200 each calendar year. • For more information about this benefit call Customer Relations at 800/686-7100. • Claims should be submitted to Kaiser Foundation Health Plan of Ohio, Claims Department, P.O. Box 5316, Cleveland, OH, 44101-9774. <p><i>The following are a few examples of services not included in your travel benefits coverage:</i></p> <ul style="list-style-type: none"> • <i>Non-emergency hospitalization</i> • <i>Infertility treatments</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> • <i>Transplants</i> • <i>DME</i> • <i>Prescription drugs</i> • <i>Home health services.</i>

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we pay them only when we determine they are medically necessary.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures at Plan facilities only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover dental procedures except as described below.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- No precertification is required for accidental injury to teeth. Services may be obtained from a licensed dentist. Please submit claims for services related to accidental injury to teeth according to Section 7 of this brochure.

Benefit Description	You Pay	
	High Option	Standard Option
Accidental injury benefit		
<p>We cover services to promptly repair (but not replace) a sound, natural tooth, if:</p> <ul style="list-style-type: none"> • damage is due to an accidental injury from trauma to the mouth from violent contact with an external object, • the tooth has not been restored previously, except in a proper manner, and • the tooth has not been weakened by decay, periodontal disease or other existing dental pathology. <p>Note: Services will be covered only when provided within 72 hours following the accidental injury.</p>	<p><i>All charges after \$500 per accidental injury.</i></p> <p><i>Nothing up to the benefit maximum of \$500 of covered charges per accidental injury.</i></p> <p><i>The maximum benefit amount we will pay is \$500 per accidental injury.</i></p>	<p><i>All charges after \$500 per accidental injury.</i></p> <p><i>Nothing up to the benefit maximum of \$500 of covered charges per accidental injury.</i></p> <p><i>The maximum benefit amount we will pay is \$500 per accidental injury.</i></p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services for conditions caused by an accidental injury occurring before your eligibility date.</i> 	<i>All charges.</i>	<i>All charges.</i>
Dental benefits	High Option	Standard Option
We have no other dental benefits.	<i>All charges.</i>	<i>All charges.</i>

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Dental Benefits

The following dental plan benefits, provided through Delta Dental of Ohio are available to all enrolled Federal employees. Your Dental Care Certificate will provide you with additional information about your Delta Dental plan, including information about your plan exclusions and limitations, and the Delta Dental Network of dentists. In the event that you seek treatment from a dentist that does not participate in any of Delta Dental's programs, in addition to your coinsurance for covered services, you will be responsible to pay the difference between the covered reimbursement of the Delta Dental PPO (to your non-Delta PPO dentist) and the dentist's total fee. To locate a Delta Dental PPO dentist, please visit www.deltadentaloh.com. For a Certificate of Insurance or more information about your dental benefits, please contact the Plan's Customer Relations Department at 216/621-7100 or 800/686-7100.

For Class I Benefits, the Plan pays 70% and you pay 30%

Diagnostic and Preventive Services, Emergency Palliative Treatment, and X-rays.

For Class II Benefits, the Plan pays 50% and you pay 50%

Oral Surgery Services for simple extractions, including preoperative and postoperative care, and Minor Restorative Services used to repair teeth damaged by disease or injury (for example, amalgam [silver] and resin [white] fillings.)

Benefits for oral examinations, prophylaxes and fluoride treatment are payable twice per calendar year. Benefits for bitewing X-rays are payable once per calendar year.

Maximum Payment - \$750 per person total per benefit year on Class I and Class II Benefits.

Deductible – None.

Benefits will cease on the last day of the month in which the employee is terminated.

Claims Address and Customer Service Phone Number:

Delta Dental Plan of Ohio

P.O. Box 9085

Farmington Hills, MI 48333-9085

1-800-282-0749

Eyeglass and Contact Lens Allowance and VAPP

The Plan provides an allowance of up to \$100 every 24 months towards the purchase of eyeglass lenses, frames or contact lenses when prescribed by a Plan physician or Plan optometrist and purchased at a United Optical location. We also offer a Value Added Purchasing Plan (VAPP) which entitles members to special discounts on designated optical goods and services purchased from designated quality vision care suppliers. For more information, contact the Plan's Customer Relations Department at 216/621-7100 or 800/686-7100.

Healthy Living Classes and Resources

Classes in prenatal care, weight management, smoking cessation and stress management are available for all Plan members. Contact the Plan's Member Service Center Health Education Line at 216/524-5948 or 800/456-6099 for details on location, times and, in some cases, member fees.

Section 6 General exclusions – things we don't cover

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

We do not cover the following:

- When a service is not covered, all services, drugs or supplies related to the non-covered service are excluded from coverage, except services we would otherwise cover to treat complications of the non-covered service;
- Care by non-Plan providers except for authorized referrals, emergencies, travel benefit, or services from other Kaiser Permanente plans (see Emergency services/accidents and Special features)
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services required for (a) obtaining or maintaining employment or participation in employee programs or (b) insurance or governmental licensing;
- Services, drugs, or supplies you receive without charge while in active military service; or
- Services provided or arranged by criminal justice institutions for members confined therein.

Section 7 Filing a claim for covered services

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

You will only need to file a claim when you receive emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 216/621-7100 or from other areas at 800/686-7100, or the TTY number at 877/676-6677.

When you must file a claim – such as for services you received outside of the Plan’s service area – submit it on the CMS-1500 or an invoice or billing statement from the provider that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to:

Claims Administration
Kaiser Foundation Health Plan of Ohio
P.O. Box 5316
Cleveland, OH 44101-9774

Deadline for filing your claim

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

When we need more information

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

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P.O. Box 93764, Cleveland, OH 44101-5764; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request - go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"> • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

	<p>Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
<p>5</p>	<p>OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.</p> <p>If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.</p> <p>OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.</p> <p>You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.</p>

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

- a) We haven’t responded yet to your initial request for care or preauthorization/prior approval, then call us at 216/621-7100, or from other areas call 800/686-7100 or the TTY number at 877/676-6677 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM’s Health Insurance Group 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary payer plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in another plan’s Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Managed Care Plan known as Kaiser Permanente Medicare Plus (an 1876 Medicare Cost Plan). Please review the information on Medicare Managed Care Plan on page 58.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D Prescription Drug Plan (PDP) coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about our prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

Please refer to the Medicare Annual Notice of Change (ANOC) or Evidence of Coverage for the complete details of your additional benefits with Kaiser Permanente’s Medicare Plus plan, which now includes Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage Plan.

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare, along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 216/621-7100 or see our Web site at my.kp.org/federalemmployees.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in another plan's Medicare Advantage plan to get your Medicare benefits. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

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

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

- **Medicare managed care plan**

You may enroll in our Medicare managed care plan known as Kaiser Permanente Medicare Plus and remain enrolled in our FEHB plan. To be eligible for Kaiser Permanente Medicare Plus, you must have Medicare Parts A and B or Medicare Part B only.

You may enroll in Medicare Plus at no additional monthly premium cost to you, if you remain enrolled in our FEHB plan. Our Medicare Plus plan offers you enhanced benefits. If you enroll in Medicare Plus, you still receive all of your in-network care through Kaiser Permanente Plan providers.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in a Medicare Part D PDP and we are the secondary payer, our Kaiser Permanente owned and operated pharmacies will not consider the PDP benefits. These Kaiser Permanente pharmacies will only provide your FEHB Kaiser Permanente benefits.

You will still need to follow the rules in this brochure for us to cover your care. We will only cover your prescription if it is written by a Plan provider and obtained at a Plan pharmacy or through our Plan mail service delivery program, except in an emergency or urgent care situation.

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
B. When you or a covered family member?		
1) Have Medicare solely based on end stage renal disease (ESRD) and • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you?		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

**TRICARE and
CHAMPVA**

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

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

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

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

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

**When other Government
agencies are responsible
for your care**

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

**When others are
responsible for injuries**

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

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

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See Section 4.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting, and taking medicine. (2) Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Custodial care that last 90 days or more is sometimes known as long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.
Durable medical equipment	Durable medical equipment (DME) is equipment that is intended for repeated use, medically necessary, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, designed for prolonged use, appropriate for use in the home, and serves a specific therapeutic purpose in the treatment of an illness or injury.
Experimental or investigational services	We carefully evaluate whether a particular therapy is safe and effective or offers a reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental literature. When the service or supply, including a drug: (1) has not been approved by the FDA; or (2) is the subject of a new drug or new device application on file with the FDA; (3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or (4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or (5) is subject to the approval or review of an Institutional Review Board; or (6) requires an informed consent that describes the service as experimental or investigational; then this Plan considers that service, supply, or drug to be experimental, and not covered by this Plan.
Group health coverage	Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Health care coverage purchased through membership in an organization is also "group health coverage."

Medically necessary	All benefits need to be medically necessary in order for them to be covered benefits. Generally, if your Plan physician provides the service in accord with the terms of this brochure, it will be considered medically necessary. However, some services are reviewed in advance of your receiving them to determine if they are medically necessary. When we review a service to determine if it is medically necessary, a Plan physician will evaluate what would happen to you if you do not receive the service. If not receiving the service would adversely affect your health, it will be considered medically necessary. The services must be a medically appropriate course of treatment for your condition. If they are not medically necessary, we will not cover the services. In case of emergency services, the services that you received will be evaluated to determine if they were medically necessary.
Our allowance	The amount we use to determine your coinsurance. When you receive services or supplies from Plan providers, it is the amount that we set for the services or supplies if we were to charge for them. When you receive services from non-Plan providers, it is either the amount that we have negotiated with the non-Plan provider, or if we do not have a negotiated amount, the amount that we believe is usual and customary for the service or supply, compared to the billed charges. Our allowance is based upon the reasonableness of the billed charges. If the billed charges exceed what we believe is reasonable, you may be responsible for the excess over our allowance in addition to your coinsurance.
Your Primary care copayment	The copayment for your primary care department visit is \$15 for the High Option plan and \$20 for the Standard Option plan for the following areas: internal medicine, pediatrics and family practice services.
Your Specialty care copayment	The copayment for your specialty care department visit is \$15 for the High Option plan and \$40 for the Standard Option plan. This copayment applies when you receive services from certain areas other than primary care (as defined above). See the brochure for the copay that applies to each service.
Us/We	Us and We refer to Kaiser Foundation Health Plan of Ohio.
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

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

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

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

- **Types of coverage available for you and your family**

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

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

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits, however, we will send you a letter notifying you when a dependent reaches the age limit. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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

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

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2006 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis.

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. If you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To request an Information Kit and application.** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents which are not covered by FEHBP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

For the HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA – Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums).

For the DCFSA – daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves.

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDES?

BENEFEDES is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental Insurance

Dental plans will provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.

- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with a 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dentalvision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

Enrollment types available

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

When can I enroll?

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season -- November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888- FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

When will coverage be effective?

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

How does this coverage work with my FEHB plan's dental or vision coverage?

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the High Option of the Kaiser Foundation Health Plan of Ohio - 2007

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

High Option Benefits	You pay	Page
Medical services provided by physicians and other health care professionals:		
• Diagnostic and treatment services provided in the office	\$15 per office visit	18
Services provided by a hospital:		
• Inpatient	\$200 per admission	35
• Outpatient	\$15 per outpatient surgery	36
Emergency benefits:		
• In-area	\$75 per visit	41
• Out-of-area	\$75 per visit	41
Mental health and substance abuse treatment:	Regular cost sharing	42
Prescription drugs:	\$10 per prescription or refill for generic drugs \$25 per prescription or refill for brand-name drugs	46
Dental care:	No benefit. See non-FEHB benefits for optional dental plan (see page 51.)	50
Vision care:	Refractions; \$15 per office visit	24
Special features: 24 hour advice line; Centers of Excellence; Flexible benefits option; Services from other Kaiser Permanente Plans; Travel benefit		48
Protection against catastrophic costs: (your catastrophic protection out-of-pocket maximum)	Nothing after \$2,000/Self Only or \$6,000/ Family enrollment per year Some costs do not count toward this protection	12

Summary of benefits for the Standard Option of the Kaiser Foundation Health Plan of Ohio - 2007

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

Standard Option Benefits	You Pay	Page
Medical services provided by physicians and other health care professionals:		
<ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	\$20 per primary care office visit \$40 per specialty care office visit	18
Services provided by a hospital:		
<ul style="list-style-type: none"> • Inpatient 	\$500 per admission	35
<ul style="list-style-type: none"> • Outpatient 	\$250 per outpatient surgery	36
Emergency benefits:		
<ul style="list-style-type: none"> • In-area 	\$100 per visit	40
<ul style="list-style-type: none"> • Out-of-area 	\$100 per visit	40
Mental health and substance abuse treatment:	Regular cost sharing	42
Prescription drugs:	\$15 per prescription or refill for generic drugs \$30 per prescription or refill for brand-name drugs	46
Dental care:	No benefit. See non-FEHB benefits for optional dental plan (see page 51.)	50
Vision care:	Refractions; \$20 per primary care office visit \$40 per specialty care office visit	24
Special features: 24 hour advice line; Centers of Excellence; Flexible benefits option; Services from other Kaiser Permanente Plans; Travel benefit		48
Protection against catastrophic costs: (your catastrophic protection out-of-pocket maximum)	Nothing after \$2,000/Self Only or \$6,000/ Family enrollment per year Some costs do not count toward this protection	12

2007 Rate Information for Kaiser Foundation Health Plan of Ohio

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	641	\$141.92	\$66.27	\$307.49	\$143.59	\$167.54	\$40.65
High Option Self and Family	642	\$321.89	\$188.99	\$697.43	\$409.48	\$380.01	\$130.87
Standard Option Self Only	644	\$118.55	\$39.52	\$256.87	\$85.62	\$140.29	\$17.78
Standard Option Self and Family	645	\$290.90	\$96.97	\$630.29	\$210.10	\$344.23	\$43.64