Kaiser Foundation Health Plan of North Carolina

1997

A Health Maintenance Organization

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

For changes in benefits see page 20

Serving: Raleigh-Durham-Chapel Hill and Charlotte

Enrollment code:
QT1 Self Only
QT2 Self and Family

Service area: Services from Plan providers are available only in the following **North Carolina** Counties:

Raleigh-Durham-Chapel Hill Area

Alamance
Caswell
Chatham
Durham
Franklin
Granville
Harnett
Johnston
Nash
Orange
Person
Vance
Wake

Charlotte Area

Cabarrus
Catawba
Gaston
Iredell
Lincoln
Mecklenburg
Rowan
Stanly
Union

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

Authorized for distribution by the :

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73-240

Kaiser Foundation Health Plan of North Carolina

Kaiser Foundation Health Plan of North Carolina, 3120 Highwoods Blvd., Raleigh, North Carolina 27604-1018, has entered into a contract (CS 2064) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Kaiser Permanente or the Plan.

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

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1997, and are shown on the inside back cover of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

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

• Call the provider and ask for an explanation - sometimes the problem is a simple error.

• If the provider does not resolve the matter, or if you remain concerned, call your plan at 1-800/755-1925 and explain the situation.

• If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

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

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

General Information

Confidentiality

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

If you are a new member

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

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

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, **you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 14.** If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See “If you are hospitalized” on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program except as stated in any cosmetic surgery or dental benefits description in this brochure.

If you are hospitalized

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

Your responsibility

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

Things to keep in mind

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

Things to keep in mind *(continued)*

- Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.
- You may also remain enrolled in this Plan when you join a Medicare prepaid plan.
- Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

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

Former spouse coverage

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

Temporary continuation of coverage (TCC)

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

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

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

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

Notification and election requirements

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

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

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

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

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

Conversion to individual coverage

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

Facts about this Plan

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

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

Who provides care to Plan members?

Kaiser Permanente offers comprehensive health care coverage through our Medical Center Physician's Option, on a prepaid group practice basis, at nine Plan medical offices and through our Community Physician's Option at designated Physician offices conveniently located throughout the Raleigh, Durham, Chapel Hill and Charlotte areas. Health Plan contracts with The Carolina Permanente Medical Group, P.A., an independent multi-specialty group of physicians, to provide or arrange all necessary physician care for Plan members. Medical care is provided through doctors, nurse practitioners and other skilled medical personnel working as medical teams. Specialists are available as part of the medical teams for consultation and treatment. Plan doctors also arrange for any necessary specialty physician care not directly available from Plan doctors. Other necessary medical services, such as physical therapy and laboratory and X-ray services, are available at Plan medical offices or by referral to specialists. Hospital care is provided through the Plan at several local community hospitals.

Role of a primary care doctor

The first and most important decision each member should make is the selection of a primary care doctor. The decision is important since this doctor arranges all other health services, particularly those of specialists. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other Plan providers and non-Plan providers are covered only when there has been a referral by the member's primary care doctor, with the following exceptions: visits to Plan obstetricians and gynecologists (OB/GYNs) and mental health providers, and health education and vision care visits arranged by the Plan.

Choosing your doctor

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, internists and OB/GYNs), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Services Representative at 919/319-3070 in the Raleigh area or toll-free from anywhere in North Carolina at 1-800/755-1925; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. **Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.**

If you enroll, you will be asked to select a primary care doctor for you and each member of your family and inform the Plan of your selection. You may see other Plan doctors if your primary care doctor is not available. Members may change their doctor selection by contacting Member Services.

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

Referrals for specialty care

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

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

For new members

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

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

Hospital care

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

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses reach $3,300 per Self Only enrollment or $8,500 per Self and Family enrollment for total copayment charges required for services provided or arranged by the Plan. This copayment maximum applies only to covered medical office visits, (including speech, occupational, and physical therapy), the first 20 covered outpatient mental health visits, covered emergency services and covered infertility services (except for infertility injections).

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

Deductible carryover

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

Submit claims promptly

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

Other considerations

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

Facts about this Plan *continued*

The Plan's service and enrollment areas

The service area for this Plan, where Plan providers and facilities are located, is the same as the enrollment area listed on the front cover of this brochure (the area in which you must live or work to enroll in the Plan). Benefits for care outside the service area are limited to emergency services, as described on page 14.

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

If you or a covered family member move outside the enrollment area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

General Limitations

Important notice

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

Circumstances beyond Plan control

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

Other sources of benefits

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

Medicare

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

Group health insurance and automobile insurance

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

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

Group health insurance and automobile insurance (*continued)*

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

CHAMPUS

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

Medicaid

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

Workers' compensation

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

DVA facilities, DoD facilities, and Indian Health Service

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

Other Government agencies

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

Liability insurance and third party actions

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

General Exclusions

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

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits);
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits and laboratory tests and X-rays; **you pay** a $10 office visit copay, but no additional copay for laboratory tests and X-rays. Office visits for prenatal care and well-baby care are provided at no charge. Within the service area, house calls will not be provided except by doctors, nurses and other professionals as part of the home health benefit listed below and if in the judgment of the Plan doctor such care is necessary and appropriate; **you pay** nothing for home health visits.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Cornea, heart, heart/lung, kidney, liver, lung (single or double) and kidney/pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Related medical and hospital expenses of the donor are covered.
- Dialysis
- Chemotherapy, radiation therapy, and respiratory therapy
- Surgical treatment of morbid obesity

What is covered
(*continued)*

- For members residing in the service area, home health services of doctors, nurses and other professional, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- Autologous blood donation expenses (including collection, processing, and storage costs) in connection with covered surgery recommended by a Plan doctor; RhoGham and gamma globulin
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you
- Blood and blood products and the administration of blood

Limited benefits

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

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery, and it occurred on or after the effective date of the member's coverage in any Plan under the Federal Employees Health Benefits Program.

Short-term rehabilitative therapy (physical, speech and occupational) and chiropractic services which are defined as manual manipulation of the spine to correct subluxation demonstrated by X-ray diagnosis of a Plan provider is provided on an inpatient or outpatient basis for up to two consecutive months per condition if significant improvement can be expected within two months; **you pay** a $10 copay per outpatient session and nothing per inpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Rehabilitation is provided on an inpatient or outpatient basis as part of a specialized multidisciplinary therapy program in a specialized facility for up to two months per condition, when in the judgment of the Plan doctor, significant improvement in functions is achievable within a period of two months; **you pay** $10 for outpatient care and nothing for inpatient care. Cognitive therapy is not covered.

Diagnosis and treatment of infertility is covered; **you pay** 50% of charges, up to the maximum member out-of-pocket expense (as described on page 8) per calendar year; nothing thereafter. **Injectable drugs and medications** for the treatment of involuntary infertility are covered; **you pay** 50% of charges. **Artificial insemination** is covered; **you pay** 50% of charges, up to the maximum member out-of-pocket expense (as described on page 8) per calendar year; nothing thereafter. The cost of donor sperm and donor eggs and services related to their procurement and storage are not covered. Other **assisted reproductive technology (ART) procedures**, such as in vitro fertilization, gamete and zygote intrafallopian transfers, are not covered. Prescribed drugs related to non-covered infertility services are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within that two months; **you pay** $10 per outpatient session, and nothing per inpatient session.

Prosthetic devices, braces, and durable medical equipment, such as artificial limbs, lenses following cataract removal, wheelchairs and hospital beds are provided for home use. Scoliosis braces, medical testing devices, electronic monitors of bodily functions (except infant apnea monitors and glucose monitors) are not covered.

Medical and Surgical Benefits *continued*

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Plastic surgery primarily for cosmetic purposes
- Externally and internally implanted hearing aids
- Chiropractic services, except for manual manipulation of the spine to correct subluxation demonstrated by X-ray diagnosis of a Plan provider (See short-term rehabilitative therapy on page 12)
- Orthopedic devices, foot orthotics; except braces
- Long term rehabilitative therapy
- Homemaker services
- Transplants not listed
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism

Hospital/Extended Care Benefits

What is covered

Hospital care

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

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

Extended care

The Plan provides a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor. **You pay** nothing. All necessary services are covered, including:

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

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home, in accordance with Medicare guidelines. Services include short-term inpatient, limited to respite care and care for pain control and acute and chronic symptom management, outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited benefits

Inpatient dental procedures

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

Acute inpatient detoxification

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

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, or care in an intermediate care facility

Emergency Benefits

What is a medical emergency?

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

Emergencies within the service area

If you are in an emergency situation, please call your Plan facility or a Plan doctor. Describe the problem and you will be given instructions as to what should be done. In extreme emergencies, if you are unable to contact the Plan or your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

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

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

Plan pays...

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

You pay...

$25 per hospital emergency room visit or $10 per urgent care center visit for emergency services that are covered benefits of this Plan, and any additional copays which would have been required if care had been rendered by the Plan. If the emergency results in admission to a hospital, the $25 emergency care copay is waived.

Emergencies outside the service area

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Plan pays...

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

You pay...

$25 per hospital emergency room visit or $10 per urgent care center visit for emergency services that are covered benefits of this Plan, and any additional copays which would have been required if care had been rendered by the Plan. If the emergency results in admission to a hospital, the $25 emergency care copay is waived.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is not covered

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

Emergency Benefits *continued*

Filing claims for non-Plan providers

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

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 18.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing (each visit counts as one outpatient individual therapy visit, and the individual therapy $10 copay noted below applies)
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 20 outpatient individual therapy visits or up to 40 group therapy visits to Plan doctors, consultants or other psychiatric personnel each calendar year. Each two group visits count as one individual visit and vice versa; **you pay** $10 per covered individual visit and $5 per covered group visit—all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** nothing for the first 30 days-all charges thereafter. Up to 60 days of day or night care per calendar year reduced by two days for each day of inpatient hospitalization and vice versa. **You pay** nothing for 60 days-all charges thereafter.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

Up to 20 outpatient individual therapy visits or up to 40 group therapy visits to Plan doctors, consultants, or other substance abuse specialists each calendar year. Each two group visits count as one individual visit and vice versa; **you pay** $10 per covered individual visit and $5 per covered group visit-all charges thereafter.

Inpatient care

Up to 30 days of inpatient care or up to 60 sessions of care in an intensive outpatient treatment program (including day or night care) for specialized treatment per calendar year. Each inpatient day used reduces the number of intensive outpatient treatment sessions by two and vice versa. **You pay** all daily charges over $100 for inpatient residential care and all daily charges over $50 for care in an intensive outpatient treatment program.

What is not covered

- Treatment that is not authorized by a Plan doctor

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by your primary care physician or a referral physician may be obtained at a Medical Center pharmacy. If you have selected the Community Physician's Option, your prescription may also be filled at a designated community pharmacy listed in your Physician Directory. Prescriptions will be dispensed for up to a 30-day supply; **you pay** a $5 copay per prescription unit or refill. You may have a prescription filled at a non-designated community pharmacy when it is written and filled after designated pharmacies are closed or as part of an out-of-area emergency. **You pay** the full cost of the prescription and then file a claim for reimbursement. If your claim is approved, you will be reimbursed the full cost of the prescription less a $5 copay. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, **you pay** the price difference between the generic and name brand drug as well as the $5 copay per prescription unit or refill.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Oral contraceptive drugs
- Contraceptive devices, diaphragms, cervical caps and intrauterine devices
- Implanted time-release medications, such as Norplant. For Norplant, **you pay** a one-time copayment of $200 per prescription. For other internally-implanted time-release medications, **you pay** a one-time copayment equal to the $5 per prescription copayment times the expected number of months the medication will be effective, not to exceed $200. There will be no refund of any portion of these copayments if the implanted time-release medication is removed before the end of its expected life.
- Insulin
- Diabetic supplies limited to blood glucose test strips and urine ketone, glucose, or protein test strips
- Disposable needles and syringes needed to inject covered prescribed medications;**you pay** nothing
- Intravenous fluids and medication for home use, some implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits.
- Certain antacids
- Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU)
- Injectable contraceptives, such as Depo Provera. **You pay** a copayment equal to the $5 per prescription copayment times the expected number of months the drug will be effective. For Depo Provera **you pay** a $15 copayment.
- Smoking cessation drugs, including nicotine patches; **you pay** $5. Coverage is limited to one course of treatment per calendar year under the following conditions: 1) the drug is prescribed by a Plan doctor; and 2) the member enrolls in and successfully completes a Plan approved smoking cessation class.
- Injectable drugs and medications for the treatment of involuntary infertility are covered; **you pay** 50% of charges.

What is not covered

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

Other Benefits

Dental care

Accidental injury benefit

Restorative services, supplies and appliances necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury occurring while the member is covered under the Plan. **You pay** 50% of the first $1,000 in charges and all charges thereafter.

Vision care

What is covered

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

- Refractions for corrective lenses (once every 24 months). **You pay** nothing.
- Frames for corrective lenses are provided once every 24 months. **You pay** nothing for frames that cost less than $20. **You receive** a $20 credit toward frames that cost more than $20.
- Regular corrective lenses are provided once every 24 months. (They may be provided more often if there is a significant change in your vision). **You pay** nothing.
- Medically required contact lenses are provided instead of regular corrective lenses. (Specific medical criteria must be met.) **You pay** nothing.
- Corrective contact lenses prescribed primarily for vision correction for conditions which do not meet specific criteria may be provided once every 24 months instead of regular corrective eyeglass lenses. **You pay** nothing for lenses that cost less than $40; for other types of lenses, **you receive** a credit of $40.
- After eye surgery, regular corrective lenses and contact lenses are provided at the same time when, if worn at the same time, they provide a significant improvement in vision that cannot be obtained by regular corrective lenses or contact lenses alone. **You pay** nothing.

What is not covered

- Industrial and athletic safety frames and lenses
- Plain (non-corrective) sunglasses
- No-line bifocals
- Plain (non-corrective) contact lenses for cosmetic purposes
- Replacement of lost or broken lenses, frames or contacts
- Lens adornment
- Fittings for contact lenses which are not medically required
- Eye exercises (orthoptics)

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Member Services Office at 919/319-3070 or 919/981-5738 TDD in the Triangle or toll free from anywhere in North Carolina at 1-800/755-1925. You may write to the Plan at the Member Services Department at 6350 Quadrangle Drive, Chapel Hill, N.C. 27514.

Disputed claims review

Plan reconsideration

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

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

OPM review

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

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

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

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

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

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

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

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

OPM review
(*continued)*

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

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

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

How Kaiser Foundation Health Plan of North Carolina Changes January 1997

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

Benefit changes

- There is a $5 copay for prescriptions written and filled in the service area after designated pharmacies are closed or as part of an out-of-area emergency. Previously, the copay was $10 for prescriptions written and filled after designated pharmacies were closed and as part of an out-of-area emergency.

Clarifications

- The brochure has been clarified to show procedures, services, drugs and supplies related to abortions are excluded 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.
- The brochure has been clarified to add lung (single or double) transplants have been added to the list of other transplants covered. Previously, the brochure did not differentiate that both single and double lung transplants were covered.
- The brochure has been clarified to show any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism is not covered. Previously, there was no brochure language regarding surgery for the purpose of refractive correction.
- "Nonexperimental implants" is now termed "The insertion of internal prosthetic devices".
- The use of a Plan identification card to obtain benefits after you are no longer enrolled in the Plan is a fraudulent action subject to review by the Inspector General.
- Medical data that does not identify individual members may be disclosed as a result of bona fide medical research or education.
- General Information—When a family member is hospitalized on the effective date of an enrollment change and continues to receive benefits under the old plan, benefits under the new plan will begin for other family members on the effective date of the new enrollment.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition.
- Annuitants and former spouses with FEHB coverage, and who are covered by Medicare Part B, may join a Medicare prepaid plan if they do not have Medicare Part A, but they will probably have to pay for hospital coverage. They may also remain enrolled under an FEHB plan when they enroll in a Medicare prepaid plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).
- Temporary continuation of coverage (TCC) for employees or family member who lose eligibility for FEHB coverage includes one free 31-day extension of coverage and may include a second. How these are coordinated has been clarified; notification and election requirements have also been clarified.
- "Conversion to individual coverage" does not require evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions; benefits and rates under the individual contract may differ from those under the FEHB Program.

Other changes

- The Plan's service area has been expanded to include Alamance, Chatham, Caswell, Granville, Harnett, Johnston, Nash, Vance, Rowan, Stanly, Union, Catawba, Gaston, Iredell, and Lincoln counties in their entirety.
- Enrollees who change their FEHB enrollments using Employee Express may call the Employee Express HELP number to obtain a letter confirming that change if their ID cards do not arrive by the effective date of the enrollment change.

How Kaiser Foundation Health Plan of North Carolina Changes January 1997

Other changes
(continued)

- The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) or equivalent agency to be payable under workers' compensation or similar Federal or State law. The Plan is entitled to be reimbursed by OWCP or the equivalent agency for services it provided that were later found to be payable by OWCP or the agency.
- The paragraph on "Liability insurance and third party actions" under "General Limitations", has been revised to explain this Plan's procedures and policies for obtaining reimbursement from a member who has recovered benefits from a third party (also known as subrogation of benefits).
- Disputed claims—If your claim for payment or services is denied by the Plan, and you decide to ask OPM to review that denial, you must first ask the Plan to reconsider their decision. You must now request their reconsideration within six months of the denial (previously, you had one year to do this). This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.
- Providers, legal counsel, and other interested parties may act as your representative in pursuing payment of a disputed claim only with your written consent. Any lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan must be brought against the Office of Personnel Management in Federal court and only after you have exhausted the OPM review procedure.

Summary of Benefits for Kaiser Foundation Health Plan of North Carolina - 1997

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

Benefits		Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	13
	Extended care	All necessary services up to 100 days per calendar year. **You pay** nothing	13
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care or 60 days of day or night care per year. **You pay** nothing	15
	Substance abuse	The Plan provides residential services such as up to 30 days of inpatient care per calendar year or up to 60 sessions of care in an intensive outpatient treatment program per calendar year. Each covered inpatient day reduces the number of intensive outpatient treatment sessions by two and vice versa. **You pay** daily charges over $100 for inpatient care and daily charges over $50 for care in an intensive outpatient treatment program	15
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay per office visit; home visits are provided under home health care below	11
	Home health care	All necessary visits by doctors, nurses and other personnel. **You pay** nothing	11
	Mental conditions	Up to 20 outpatient individual visits or up to 40 outpatient group visits per year. **You pay** $10 each for individual visits, or $5 each for group visits.	15
	Substance abuse	Up to 20 outpatient individual visits or up to 40 outpatient group visits per year. **You pay** $10 each for individual visits, or $5 each for group visits	15
Emergency care		Reasonable charges for services required because of a medical emergency. **You pay** a $25 copayment for each emergency room visit, applicable Plan copayments, and all charges for non-covered benefits	14-15
Prescription drugs		Drugs prescribed by a Medical Center doctor or participating Community doctor and obtained at a pharmacy designated in the Physician Directory; **you pay** a $5 copay per prescription unit or refill. You may use a non-designated pharmacy only when designated pharmacies are closed or you have an out-of-area emergency.	16
Dental care		Accidental injury benefit; **you pay** 50% of the first $1,000 in charges and all charges thereafter.	17
Vision care		Refractions, corrective lenses, medically necessary contact lenses. **You pay** nothing. You receive a $20 credit towards frames for corrective lenses and a $40 credit for certain contact lenses as shown. Refractions, frames, corrective lenses or contact lenses are provided once every 24 months	17
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $3,300 per Self Only or $8,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum applies only to covered services indicated on page 8 under the "Out-of-Pocket Maximum" section	8

NOTES