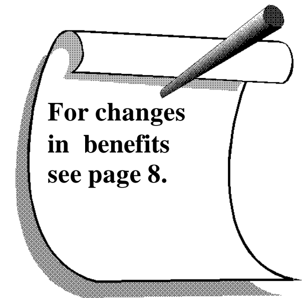
# Keystone Health Plan Central 2002

http://www.khpc.com

## A Health Maintenance Organization




**Serving:** Harrisburg, Lehigh Valley and Northern Tier areas of Pennsylvania

**Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.**

This Plan has an Excellent accreditation from the NCQA. See the 2002 Guide for more information on NCQA.

**Enrollment codes for this Plan:**

**S41 Self Only**
**S42 Self and Family**

Authorized for distribution by the:

**United States**
**Office of Personnel Management**

Retirement and Insurance Service
http://www.opm.gov/insure

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## Introduction

Keystone Health Plan Central
P.O. Box 898812
Camp Hill, PA  17089-8812

This brochure describes the benefits of Keystone Health Plan Central under our contract (CS 2076) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. Rates are shown at the end of this brochure.

## Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures 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" means Keystone Health Plan Central.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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

## Inspector General Advisory

### Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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 800/622-2843 and explain the situation.
- If we do not resolve the issue, call or write:

**THE HEALTH CARE FRAUD HOTLINE**
**202/418-3300**
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415.

**Penalties for Fraud**

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

# Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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 claim forms or pay bills. You only pay the copayments, and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

## How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

## Who provides my health care?

Keystone Health Plan Central is an Individual Practice Prepayment (IPP) Plan. As a member, you select a primary care physician (PCP) from among the Plan's participating Family Practitioners, Internists, and Pediatricians. You can choose from over 1,500 primary care physicians who currently participate in the Plan.

## Your Rights

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

As a Member of KHP Central, you may submit a written request for any of the following written information:

- A list of the names, business addresses and official positions of the membership of our board of directors or officers.
- The procedures adopted by us to protect the confidentiality of your medical records and other member information.
- A description of the credentialing process for participating providers.
- A list of the participating providers affiliated with participating hospitals.
- Whether a specifically identified drug is included or excluded from your coverage.
- A description of the process by which a participating provider can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in our selective drug formulary for prescription drugs or biologicals when the formulary's equivalent has been ineffective in the treatment of your disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions in your case, if applicable to your coverage.
- A description of the procedures followed by us to make decisions about the experimental nature of individual drugs, medical devices or treatments.
- A summary of the methodologies used by us to reimburse providers for covered services. Please note that we will not disclose the terms of individual contracts or the specific details of any financial arrangement between us and a participating provider.
- A description of the procedures used in our Quality Assurance Program.

Your request must specifically identify what information is being requested and should be sent to:

**Keystone Health Plan Central**
**P.O. Box 898880**
**Camp Hill, PA 17089-8880**

If you want more information about us, call 1-800/622-2843, or write to Keystone Health Plan Central, Attn: Member Services, P.O. Box 898880, Camp Hill, PA, 17089-8880. You may also contact us by fax at 717/302-0257 or visit our website at www.khpc.com

## Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

**Harrisburg**: The Pennsylvania counties of Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Perry, Schuylkill and York.

**Lehigh Valley:** The Pennsylvania counties of Lehigh and Northampton

**Northern Tier:** The Pennsylvania counties of Centre, Columbia, Juniata, Mifflin, Montour, Northumberland, Snyder and Union.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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 check with us to see if a Guest Membership can be established or 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.

If you are traveling outside the Plan's service area and require urgent care, you need to use the following procedure:

- Contact the 24-hour, toll-free provider locator service at 1-800-810-2583 or log on to www.bcbs.com.
- You will receive information regarding three available local providers (names, addresses, phone numbers, and directions) who can meet your medical needs.
- You will need to select a provider and schedule your own appointment.
- At the appointment, you must present your Plan Medical ID card and pay the applicable copayment while you are at your appointment.
- You must contact your Primary Care Physician to advise the office of your need for medical attention and coordinate any necessary follow-up care.

Your away-from-home travel isn't always measured in day trips or week vacations. That's why we also provide care when someone's away a long time, whether it's extended out-of-town business, semesters at school or families living apart. For anyone away at least 90 days, we offer Guest Membership at an affiliated HMO near your travel destination. Guest Membership allows you or your family to enjoy the full range of benefits offered by the Host HMO.

For more details, please contact KHPC at 1-800/622-2843 and ask to speak with the Guest Membership Coordinator.

# Section 2. How we change for 2002

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

## Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8))

## Changes to this Plan

- Your share of the non-Postal premium will increase by 61.3% for Self Only or 50.8% for Self and Family.
- We now cover certain intestinal transplants. (Section5(b))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section5(a))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now require that blood glucose monitors be obtained from a Plan pharmacy subject to a $10 copay. Only one (1) blood glucose monitor will be covered in a calendar year. (Section 5 (f))
- We now cover oral appliances used to treat sleep apnea under "Durable medical equipment" subject to a maximum Plan payment of $340 per appliance. Member is responsible for any remaining amount above the Plan maximum. (Section 5 (a))
- We no longer cover inpatient hospice care. (Section 5 (c))
- We now cover oral chemotherapy under the "Prescription drug benefit," subject to the applicable drug copay. Injectable chemotherapy is subject to no copay, when we preauthorize treatment or, if an office visit is necessary, a $10 office visit copay. (Sections 5 (a) and 5 (f)

## 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 (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-622-2843.

### 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, unless you receive emergency services from a provider who doesn't contract with us.

- **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 credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website. You can view our website at www.khpc.com or call our Member Service Department at 1-800/622-2843 to request a provider directory.

- **Plan facilities**

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 in the provider directory, which we update periodically. The list is also on our website. You can view our website at www.khpc.com or call our Member Service Department at 1-800/622-2843 to request a Provider Directory.

### 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. You must select a Primary Care Physician (PCP) from our provider directory. You can request a provider directory from us by calling 1-800/622-2843 or search for a PCP on our website at www.khpc.com.

- **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.

If you need medical services after normal office hours, contact your PCP. The PCP's answering service may take your call. If so, the answering service will contact your physician or the physician on call, who will contact you as soon as possible. Please allow fifteen (15) minutes for Emergent situations and one (1) hour for urgent situations for the physician to return your call. Try to keep your phone free in the

meantime. Limit after-hours calls to medical problems requiring immediate attention. Do not postpone calling your PCP's office if you feel you need medical attention; however, please do not call after scheduled office hours to obtain test results, prescription refills or other non-urgent matters.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see certain specialists to receive services without a referral as described below. If your PCP determines that you need specialized services, he or she will provide you with a referral form to the appropriate Participating Provider. Some services will also require prior authorization from KHPC. If you wish to change the specialist to whom you have been referred, contact your PCP for a new referral form.

Your PCP will give you a referral for medically necessary care. The referral form will indicate the services to be performed by the specialist or facility and any specific timeframe for which the referral is valid. The specialist or facility must contact the PCP before providing additional services not listed on the form. In some cases, you will be required to obtain an additional referral form from the PCP for the requested additional services. It is important to note that all laboratory services must be obtained using the PCP's laboratory arrangement listed on your ID card. Referrals are good only for the provider listed on the referral form. If you need additional services or if you need to see another provider, you should call your PCP.

Certain services require prior authorization by KHPC's Utilization Management Department. We recommend you consult with your provider before having services rendered to ensure that he or she has obtained the proper prior authorization from KHPC for the listed services.

If you are afflicted with a life-threatening, degenerative or disabling disease or condition, a standing Referral may be given to your specialist with the appropriate clinical experience in treating the condition, or, in certain cases, your specialist may be designated to provide and coordinate your primary and specialty care. In order to receive a standing referral, a referral form must be obtained by your primary care physician. The referral form allows the specialist to perform the treatment required for a specific episode of illness, for up to ninety (90) days. The specialist may refer you for additional services, including laboratory testing, radiology, diagnostic testing or durable medical equipment (DME). Having your specialist designated to provide and coordinate your care requires approval of the Plan. You must submit your request in writing.

Obstetrical and Gynecological Care. Services provided to you for obstetrical and gynecological care do not require a referral from your PCP. You are permitted to contact your Obstetrical/Gynecological specialist directly and seek treatment. The services permitted are limited to those encompassed by and unique to the specialty of obstetrics and gynecology, including follow-up care and must be performed by a participating OB/GYN Provider. If you have any questions, please

contact the specialist, PCP or KHPC to ensure that your treatment is considered to be obstetrical or gynecological. The specialist is to notify your PCP of all services and treatment you receive. This will ensure the continuity of your care. Please note that all prior authorization guidelines still apply.

Retroactive referrals are *not* permitted by KHPC. You must obtain the referral form before receiving services other than obstetrical, gynecological, or emergency services.

Mental Health and Substance Abuse Treatment. Management of mental health and/or substance abuse treatment is provided through a subcontract with Magellan Behavioral Health, a behavioral health managed care company that maintains a network of qualified mental health care professionals who offer care to KHPC Members.

A particular mental health provider group is assigned to your PCP. You may contact your PCP or our Member Service Department at 1-800/622-2843 toll-free (TDD number at 1-800/669-7075) or Magellan Behavioral Health at 1-800/688-1911 (TDD number at 1-800/409-8640) to find out which mental health provider group is assigned to your PCP. Magellan Behavioral Health also offers translator services to its non-English speaking members. To access this service, simply call Magellan Behavioral Health at 1-800/874-9426. The Mental Health Provider group will be responsible for providing and/or coordinating your mental health/substance abuse treatment.

If you need mental health and/or substance abuse services, you may contact your assigned mental health provider group directly and schedule an appointment (no PCP referral form is needed). If the outpatient non-emergency services you receive are not from the mental health provider group assigned to your PCP, these services will NOT be covered. If faced with a crisis, call your assigned mental health provider group, or contact Magellan Behavioral Health at 1-800/688-1911(TDD number at 1-800/409-8640). The Magellan Behavioral Health Care Management Team and your mental health care provider are available 24-hours a day, seven days a week, to offer assistance and coordinate care.

Here are 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 work with your specialist to 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 (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another

specialist.  You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  – terminate our contract with your specialist for other than cause; or

  – drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  – reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care.  This includes admission to a skilled nursing or other type of facility.  To receive hospital care, we must authorize all admissions.

If you are in the hospital when your enrollment in our Plan begins, call our member service department immediately at 1-800/622-2843.  If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the benefits of the hospitalized person.

## Circumstances beyond our control

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

## Services requiring our prior approval

Your primary care physician has the 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 prior authorization.  Your physician must obtain prior authorization for the following services, which include, but are not limited to:

- Admissions - all facility admissions, including skilled nursing and rehabilitation
- Allergy - all allergy injections by a specialist beyond the first injection for each new vial
- Ambulance - ambulance transport (for other than true emergencies)
- Bone Mineral Density Studies
- Cancer therapies - intravenous chemotherapy and radiation therapy
- DME - all eligible rental items and/or all eligible purchased items with a cost of $100 or more per item
- Drug therapies prior authorized by KHPC (not a Pharmacy Benefits Manager [PBM]):
  - -- Remicade infusion therapy
  - -- Visudyne/Photodynamic therapy
  - -- Rabies Vaccine & Immunoglobulin
  - ❖ The following commonly self-administered drugs when given by a health care professional (beyond the first 2 injections):
    - -- Epogen/Procrit (except when used in the treatment of chronic renal failure)
    - -- Neupogen
    - -- Leukine
    - -- Neumega
    - -- Interferons (examples include, but are not limited to, Roferon-A, Alferon N, Intron A, Betaseron, and Avonex)
    - -- Sandostatin
    - -- Enbrel
- Education/training - diabetic teaching, nutritional counseling, and all other education/training services
- Emergency room - emergency room care for other than true emergencies
- Epidurals - epidural injections performed in an outpatient or office setting
- Gastroenterology services - esophagoscopies, gastroscopies, duodenoscopies (and combinations thereof), colonoscopies, and ERCP's (endoscopic retrograde cholangiopancreatographies)
- Genetic testing
- Hemodialysis (renal dialysis)
- Home health services - including home monitoring
- Hospice care
- Imaging procedures - MRI, MRA, CT Scan, PET Scan, SPECT Scan
- Infertility - all services, diagnostic testing and treatment
- Manipulation therapy - spinal and other body part manipulation therapy (including chiropractic care) not provided by the Primary Care Physician
- Maternity Care - all prenatal and maternity care (including all diagnostic testing beyond the global maternity policy)
- Non-contracted providers - all services provided by non-contracted providers
- Nuclear medicine
- Office Surgical Procedures - all services on the Office Surgical Procedures list when performed outside the physician office setting
- Rehabilitative therapies - all rehabilitative therapies, such as physical, occupational, speech, cardiac, respiratory, vision, and urinary incontinence

- Surgeries - all facility based surgeries, including hospitals and ambulatory surgical centers (excluding endoscopic procedures except those listed in bulleted item 11)
- Transplant evaluations.

We recommend that you consult with your provider before you receive services to make sure that he or she has obtained the correct prior authorization from us before treatment begins.

## Section 4. Your costs for covered services

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

- **Copayments**

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

Examples: When you see your primary care physician (PCP) you pay a copayment of $10 per office visit. If you see your PCP for services after the hours normally scheduled for office services you will pay $20 per visit.

If you use an emergency room for services you will pay $25 per visit. This copayment is waived if you are admitted to the hospital at that time. If you are sent to the emergency room by your PCP or by us to receive services the PCP could have performed in his/her office, you will pay $10 per visit.

- **Deductible**

We do not have a deductible.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

- **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: You pay 50% of our allowance for services and medications to treat infertility, and medications for treatment of sexual dysfunction.

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

We do not have an out-of-pocket maximum.

# Section 5. Benefits – OVERVIEW

***(See page 8 for how our benefits changed this year and page 62 for a benefits summary.)***

**NOTE**: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 800/622-2843 (TDD 800/669-7075) or at our website at www.khpc.com.


(a) Medical services and supplies provided by physicians and other health care professionals ..........16-27

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Physical, Occupational & Rehabilitative therapies
- Speech therapy
- Hearing services (testing, treatment, and supplies)
- Vision services (testing, treatment, and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Chiropractic
- Alternative treatments
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals ..........28-31

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services ..........32-34

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents ..........35-36

- Medical emergency
- Ambulance

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

I M P O R T A N T

**Here are some important things to 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 costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

I M P O R T A N T

| Benefit Description | You pay |
|---|---|
| **Diagnostic and treatment services** | |
| Professional services of physicians<br>• In physician's office | $10 per office visit.<br><br>$20 per office visit if you see your Plan PCP for services during hours other than those regularly scheduled for appointments. |
| Professional services of physicians<br>• In an urgent care center<br>• During a hospital stay<br>• In a skilled nursing facility<br>• Office medical consultations<br>• Second surgical opinion | <br>$25 per visit.<br>Nothing.<br>Nothing.<br>$10 per office visit.<br>$10 per office visit. |
| At home | Nothing. |

| Lab, X-ray and other diagnostic tests | You pay |
|---|---|
| Tests, such as:<br>• Blood tests<br>• Urinalysis<br>• Non-routine pap tests<br>• Pathology<br>• X-rays<br>• Non-routine Mammograms<br>• Cat Scans/MRI<br>• Ultrasound<br>• Electrocardiogram and EEG | Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.<br><br>$10 per office visit if you must have an office visit to receive these services. |
| **Preventive care, adult** | |
| Routine screenings, such as:<br>• Vision or hearing<br>• Total Blood Cholesterol – once every three years<br>• Sigmoidoscopy, screening – every five years starting at age 50<br>• Colorectal Cancer Screening, including<br>–Fecal occult blood test<br>Prostate Specific Antigen (PSA test) – one annually for men age 40 and older<br>Routine pap test | Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.<br><br>$10 per office visit if you must have an office visit to receive these services. |
| Note: If you are diabetic you may self-refer for one diabetic retinopathy screening to a Plan ophthalmologist or optometrist. You will receive a letter notifying you of this benefit each year. Take this letter with you to your appointment with the Plan eye specialist. | Nothing. |
| Routine mammogram –covered for women age 35 and older, as follows:<br>• From age 35 through 39, one during this five year period<br>• From age 40 and older, one every calendar year<br>Female members under age 40 must get a referral from their Plan doctor for a screening mammogram; female members age 40 and over may self-refer to a participating provider for an annual screening mammogram | Nothing when this is part of your annual OB/GYN examination or when your Plan provider refers you. |
| *Not covered:*<br>• *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*<br>• *Vision examinations for refractive corrections* | *All charges.* |

| **Preventive care, adult** *(Continued)* | **You pay** |
|---|---|
| Routine Immunizations, including but not limited to:<br>• Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations)<br>• Influenza vaccine, annually, age 50 and over<br>• Pneumococcal vaccine, one injection, age 65 and over | Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.<br><br>$10 per office visit if you must have an office visit to receive these services. |
| **Preventive care, children** | |
| • Childhood immunizations recommended by KHPC Health Maintenance guidelines | Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.<br><br>$10 per office visit if you must have an office visit to receive these services. |
| • Well-child care charges for routine examinations, immunizations and care (up to age 22)<br><br>• Examinations by your PCP, such as:<br>–Eye exams through age 17 to determine the need for vision correction<br>–Ear exams through age 17 to determine the need for hearing correction<br>–Examinations done on the day of immunizations (up to age 22) | Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.<br><br>$10 per office visit if you must have an office visit to receive these services. |
| Note: If you are diabetic you may self-refer for one diabetic retinopathy screening to a Plan ophthalmologist or optometrist. You will receive a letter notifying you of this benefit each year. Take this letter with you to your appointment with the Plan eye specialist. | Nothing. |
| *Not covered: Vision examinations for refractive corrections* | *All charges.* |

| Maternity care | You pay |
|---|---|
| Complete maternity (obstetrical) care, such as:<br>• Prenatal care<br>• Delivery<br>• Postnatal care<br>Note: Here are some things to keep in mind:<br>• Your doctor must obtain prior authorization for your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby.<br>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. If you are discharged prior to these times you are eligible to receive one home health care visit within 48 hours of your discharge.<br>• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.<br>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). | Nothing when we prior authorize your treatment. |
| *Not covered: Routine sonograms to determine fetal age, size or sex.* | *All charges.* |
| **Family planning** | |
| A broad range of voluntary family planning services, such as:<br>• Voluntary sterilization<br>• Surgically implanted contraceptives (such as Norplant)<br>• Injectable contraceptive drugs (such as Depo provera)<br>• Intrauterine devices (IUDs)<br>• Diaphragms | Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.<br>$10 per office visit if you must have an office visit to receive these services |
| Note: We cover oral contraceptives under the prescription drug program. | Applicable prescription drug copay |
| Note: Your physician cannot dispense the contraceptive form of Depo provera from the office. You must get it at the pharmacy. | Applicable 90-day prescription drug copay |
| *Not covered: reversal of voluntary surgical sterilization, genetic counseling,* | *All charges.* |

| Infertility services | You pay |
| --- | --- |
| Diagnosis and treatment of infertility, such as:<br>• Artificial insemination:<br>–*intravaginal insemination (IVI)*<br>–*intracervical insemination (ICI)*<br>–*intrauterine insemination (IUI)* | 50% of the cost of treatment when authorized by KHPC. |
| • Fertility drugs<br><br>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. | 50% of the cost of the medications. You can receive up to a 90-day supply at one time. |
| *Not covered:*<br>• *Assisted reproductive technology (ART) procedures, such as:*<br>–*In vitro fertilization*<br>–*Embryo transfer, gamete GIFT and zygote ZIFT*<br>• *Services and supplies related to excluded ART procedures*<br>• *Cost of donor sperm*<br>• *Cost of donor egg* | *All charges.* |

| Allergy care | You pay |
| --- | --- |
| Testing and treatment | $10 per office visit. |
| Allergy serum<br><br>Allergy injection | Nothing. |
| *Not covered: provocative food testing and sublingual allergy desensitization* | *All charges.* |

| Treatment therapies | You pay |
|---|---|
| • Chemotherapy and radiation therapy<br>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 30. We cover injectable chemotherapy under the medical benefit and oral chemotherapy under the prescription drug benefit.<br>• Respiratory and inhalation therapy<br>• Dialysis – Hemodialysis and peritoneal dialysis<br>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy | Nothing when we prior authorize your treatment. |
| • Growth hormone therapy (GHT) These are covered under your prescription drug program and require prior authorization from us and the drug vendor (these drugs are on the prior authorization list.)<br>Note: – We will only cover GHT when the treatment is prior authorized. You must ask your Plan doctor to submit information that establishes that the GHT is medically necessary. Your Plan doctor must ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date your provider submits the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior authorization* in Section 3. | $10 copay per 30-day supply or unit of use at a participating pharmacy. |
| **Physical, Occupational, and Rehabilitative therapies** | |
| Physical therapy, occupational therapy, respiratory therapy, orthoptic therapy, urinary incontinence therapy and cardiac therapy --<br>• 60 visits per condition for the services of each of the following:<br>–Qualified physical therapists; occupational therapists, respiratory therapists; orthoptic therapists; urinary incontinence therapists and cardiac therapists.<br>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. | Nothing when we prior authorize your treatment and you are referred by your Plan provider. |
| *Not covered:*<br>• *Long-term rehabilitative therapy*<br>• *Exercise programs*<br>• *Rehabilitative therapy services, including spinal manipulation therapy, for chronic problems or routine maintenance for chronic conditions* | *All charges.* |

| Speech Therapy | You pay |
|---|---|
| • 60 visits per condition for the services of qualified speech therapists | Nothing when we prior authorize your treatment and you are referred by your Plan provider. |
| **Hearing services (testing, treatment, and supplies)** | |
| • Hearing screenings for children through age 17 (see *Preventive care, children*) | Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.<br><br>$10 per office visit if you must have an office visit to receive these services. |
| *Not covered:*<br>• *all other hearing testing*<br>• *hearing aids, testing and examinations for them* | *All charges.* |
| **Vision services (testing, treatment, and supplies)** | |
| • Vision screening to determine the need for vision correction for children through age 17 (see preventive care)<br>• Vision screening for diagnostic purposes when related to a medical diagnosis when provided or referred by your Plan doctor | Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.<br><br>$10 per office visit if you must have an office visit to receive these services. |
| Note: If you are diabetic you may self-refer for one diabetic retinopathy screening to a Plan ophthalmologist or optometrist. You will receive a letter notifying you of this benefit each year. Take this letter with you to your appointment with the Plan eye specialist. | Nothing |
| *Not covered:*<br>• *Eyeglasses or contact lenses or the fitting of contact lenses, except one pair of standard eyeglasses or contact lenses following cataract surgery when the physician does not prescribe an intraocular lens.*<br>• *Radial keratotomy and other refractive surgery* | *All charges.* |

| Foot care | You pay |
| --- | --- |
| Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes<br><br>See orthopedic and prosthetic devices for information on podiatric shoe inserts | $10 per office visit. |
| *Not covered:*<br>• *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*<br>• *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)* | *All charges.* |
| **Orthopedic and prosthetic devices** | |
| • Artificial limbs and eyes; stump hose.<br>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy<br>• Intraocular lenses following cataract removal<br>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome<br>• Foot orthotics<br>• Braces<br>• Internal prosthetic devices, such as artificial joints, pacemakers, defibrillators, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. | Nothing when prior authorized by us and purchased from an approved supplier. |
| *Not covered:*<br>• *Orthopedic and corrective shoes*<br>• *Arch supports*<br>• *Heel pads and heel cups*<br>• *Lumbosacral supports*<br>• *Cost of penile implanted device* | *All charges.* |

| Durable medical equipment (DME) | You pay |
|---|---|
| Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:<br>• hospital beds<br>• wheelchairs<br>• crutches<br>• canes<br>• walkers<br>• traction equipment<br>• physiotherapy equipment<br>• ostomy supplies<br>• insulin pumps, and diabetic orthotics<br><br>Note: Diabetic-related supplies and blood glucose monitors are covered under Prescription drug benefits. | Nothing when prior authorized by us and purchased from an approved supplier.<br><br>$10 per office visit for evaluation or fitting. |
| • hair prostheses limited to 2 per member per calendar year with a maximum Plan payment of $400 per prosthesis | Any remaining amount above the Plan maximum of $400 per prosthesis, with a limit of 2 per member per calendar year. |
| • Oral appliances for sleep apnea are limited to a maximum Plan payment of $340 per appliance | Any remaining amount above the Plan maximum of $340 per appliance. |
| *Not covered:*<br>• *Supplies determined by KHPC to be not medically necessary* | *All charges.* |
| **Home health services** | |
| • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.<br>• Services include oxygen therapy, intravenous therapy and medications. | Nothing when we prior authorize your treatment. |
| Not covered:<br>• *nursing care requested by, or for the convenience of, the patient or the patient's family;*<br>• *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* | *All charges.* |

| Chiropractic | You pay |
|---|---|
| • You can receive chiropractic services or manipulation therapy services for acute care when the services are associated with an accident or injury and prior authorized by KHPC. You must seek treatment within one week of the accident or injury and your benefit period is limited to a maximum of two (2) weeks of acute care. Services are limited to X-rays, an initial consultation or office visit, certain types of manipulation therapy and physical therapy. | Nothing for therapy when we prior authorize your treatment;<br><br>$10 per office visit to your primary care physician or specialist. |
| *Not covered:*<br>• *Chronic problems and routine chiropractic maintenance services* | *All charges.* |
| **Alternative treatments** | |
| *Not covered:*<br>• *Naturopathic services*<br>• *Hypnotherapy*<br>• *Biofeedback*<br>• *Acupuncture* | *All charges.* |
| **Educational classes and programs** | |
| Coverage includes:<br><br>• Childbirth Preparation Classes: You can receive up to a $75 reimbursement for Childbirth Preparation Classes. After you enroll in a course and make the initial payment, forward your certificate of completion and your receipt to us for reimbursement. | Any balance over our $75 reimbursement. |
| • Diabetes Education Classes. You are eligible to attend diabetic education classes through approved facilities. These classes are designed to provide you with the skills necessary to manage diabetes. The classes, which require prior authorization, are available to all of our members with a diagnosis of diabetes. | Nothing when we prior authorize your treatment. |

| **Educational classes and programs** *(Continued)* | **You pay** |
|---|---|
| • Depending on the type and severity of your condition or disease, you may require different levels of assistance from the Plan to help you manage it. Your plan offers educational, support and active disease management programs to members with the following diseases: Depression, Diabetes, and Asthma.<br><br>• The Plan offers Intense Care Management if your symptoms require complex care. Care managers work with you to design a personalized program with your special needs in mind. This program is available to you if you have any of the following conditions: Diabetes, Congestive Heart Failure, Hip Fracture, Chronic Obstructive Pulmonary Disease, High Risk Maternity, and Asthma.<br><br>• Nicotine Cessation Health Management Program. Our nicotine cessation program uses a combination of over-the-counter nicotine replacement therapy (when appropriate), behavior modification and telephonic counseling to assist you in your efforts to stop smoking. It can be initiated through your PCP or by calling a Member Service Representative at 1-800/622-2843 toll-free (TDD number at 1-800/669-7075) for the hearing impaired.<br><br>• Smart Surgery. The success of your surgery and recovery are important to us. In fact, research has shown that increasing a patient's knowledge of any given procedure and what to expect during a recovery can significantly reduce anxiety. The Plan has developed materials targeting selected surgical procedures. The information explains what you can expect before and after the recovery phase of your surgical admission. | Nothing. |

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

IMPORTANT

**Here are some important things to 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 nocalendar year deductible.
- Be sure to read Section 4, *Your costs 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 and identify which surgeries require precertification.

IMPORTANT

| Benefit Description | You pay |
|---|---|
| **Surgical procedures** | |
| A comprehensive range of services, such as:<br>• Operative procedures<br>• Treatment of fractures, including casting<br>• Normal pre- and post-operative care by the surgeon<br>• Endoscopy procedures<br>• Biopsy procedures<br>• Removal of tumors and cysts<br>• Correction of congenital anomalies (see reconstructive surgery)<br>• Surgical treatment of morbid obesity<br>• Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information<br>• Voluntary sterilization<br>• Treatment of burns | Nothing when we prior authorize your treatment. |
| *Not covered:*<br>• *Reversal of voluntary sterilization*<br>• *Routine treatment of conditions of the foot; see Foot Care*<br>• *Any services determined to be not medically necessary by KHPC* | *All charges.* |

| Reconstructive surgery | You pay |
|---|---|
| • Surgery to correct a functional defect<br>• Surgery to correct a condition caused by injury or illness if:<br>–the condition produced a major effect on the member's appearance and<br>–the condition can reasonably be expected to be corrected by such surgery<br>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.<br>• All stages of breast reconstruction surgery following a mastectomy, such as:<br>–surgery to produce a symmetrical appearance on the other breast;<br>–treatment of any physical complications, such as lymphedemas;<br>–breast prostheses and surgical bras and replacements (see Prosthetic devices).<br><br>Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. | Nothing when we prior authorize your treatment. |
| *Not covered:*<br>• *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*<br>• *Surgeries related to sex transformation*<br>• *Any services determined to be not medically necessary by KHPC* | *All charges.* |
| **Oral and maxillofacial surgery** | |
| Oral and maxillofacial surgical procedures include, but are not limited to:<br>• Surgical correction of congenital defects, such as cleft lip and cleft palate;<br>• 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;<br>• Removal of stones from salivary ducts;<br>• Excision of leukoplakia or malignancies;<br>• Services for the extraction of impacted teeth when partially or totally covered by bone. Services will be fully covered and may be provided to you on an outpatient or, when medically necessary, inpatient basis;<br>• Other surgical procedures that do not involve the teeth or their supporting structures; and<br>• Treatment of TMJ, including surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy.<br><br>Note: If you receive services on an inpatient basis, your doctor must obtain prior authorization from us before we will cover your surgery. | Nothing. |

| **Oral and maxillofacial surgery** *(Continued)* | **You pay** |
|---|---|
| *Not covered:*<br>• *Oral implants and transplants*<br>• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), including any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome* | *All charges.* |
| **Organ/tissue transplants** | |
| Include but are not limited to:<br>• Cornea<br>• Heart<br>• Heart/lung<br>• Kidney<br>• Liver<br>• Lung: Single –Double<br>• Pancreas<br>• Small bowel<br>• Allogeneic (donor) bone marrow transplants<br>• 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.<br>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas.<br>• If not eligible for payment by any other source, the following services of donors to a KHPC Member recipient are covered: removal of the organ from the donor; donor preparatory pathologic and/or medical examinations; donor post-surgical care. | Nothing when we prior authorize your treatment. |
| *Not covered:*<br>• *Donor screening tests and donor search expenses*<br>• *Transplants not listed as covered*<br>• *Any treatment, procedure, facility, equipment, drug, drug application, drug usage device or supply, which we determine is not accepted as standard medical treatment for the condition being treated. We rely on available credible data and the advice of the medical community, including but not limited to medical consultants, medical journals and/or government regulations, to guide us in our decisions.*<br>• *Any such items requiring federal or other governmental agency approval for which approval has not been granted for the condition being treated or the manner in which the items are being used at the time services were rendered or requested.* | *All charges.* |

| Anesthesia | You pay |
|---|---|
| Professional services provided in –<br><br>• Hospital (inpatient)<br>• Hospital outpatient department<br>• Skilled nursing facility<br>• Ambulatory surgical center<br>• Office | Nothing when we prior authorize your treatment. |

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

IMPORTANT

**Here are some important things to remember 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.
- Be sure to read Section 4, *Your costs 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 covered in Section 5(a) or (b).
- **YOUR PLAN PROVIDER MUST GET PREAUTHORIZATION FOR ALL HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

IMPORTANT

| Benefit Description | You pay |
|---|---|
| **Inpatient hospital** | |
| Room and board, such as<br>• ward, semiprivate, or intensive care accommodations;<br>• general nursing care; and<br>• meals and special diets.<br><br>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.<br><br>Other hospital services and supplies, such as:<br>• Operating, recovery, maternity, and other treatment rooms<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests and X-rays<br>• Administration of blood and blood products<br>• Dressings, splints, casts, and sterile tray services<br>• Medical supplies and equipment, including oxygen<br>• Anesthetics, including nurse anesthetist services<br>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home | Nothing when we prior authorize your treatment. |
| *Not covered:*<br>• *Custodial care*<br>• *Non-covered facilities, such as nursing homes and schools*<br>• *Personal comfort items, such as telephone, television, barber services, guest meals and beds*<br>• *Private nursing care unless medically necessary*<br>• *Take-home items*<br>• *Whole blood, blood plasma or blood components* | *All charges.* |

| Outpatient hospital or ambulatory surgical center | You pay |
|---|---|
| • Operating, recovery, and other treatment rooms<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests, X-rays, and pathology services<br>• Administration of blood, blood plasma, and other biologicals<br>• Pre-surgical testing<br>• Dressings, casts, and sterile tray services<br>• Medical supplies, including oxygen<br>• Anesthetics and anesthesia service<br><br>NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. | Nothing when we prior authorize your treatment. |
| *Not covered: Whole blood, blood and blood products.* | *All charges.* |
| **Extended care benefits/skilled nursing care facility benefits** | |
| Extended care benefit: You are eligible for an unlimited number of days of extended care when full time skilled nursing care is necessary and confinement in a skilled nursing facility is determined to be medically appropriate by your Plan doctor and approved by us. We cover all necessary services including but not limited to:<br>• Room, board and general nursing care<br>• Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor. | Nothing when we prior authorize your treatment. |
| Not covered: custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care. | *All charges.* |
| **Hospice care** | |
| You are eligible for supportive and palliative care up to a maximum of $7500 when you become terminally ill with a life expectancy of six months or less. These services must be provided in your home and can include outpatient care and family counseling. These services are provided under the direction of your Plan doctor, who certifies that you are in the terminal stages of illness, with a life expectancy of approximately six months or less. | Nothing when we prior authorize your treatment. |
| • *Not covered: Independent nursing, homemaker services, and inpatient hospice care* | *All charges.* |

| Ambulance | You pay |
|---|---|
| • You can receive medically necessary ambulance services when required in connection with emergency services or when your Plan provider orders and we prior authorize them in connection with non-emergent care. | Nothing when we prior authorize your treatment. |

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

IMPORTANT

**Here are some important things to keep in mind about these benefits:**

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

IMPORTANT

### What is a medical emergency?

**An "Emergency Service" is defined as any health care service provided to you or someone in your family after the** *sudden onset* **of a medical condition that manifests itself by** *acute symptoms* **of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could** *reasonably* **expect the absence of** *immediate* **medical attention to result in:**

- Placing your health, or with respect to a pregnant woman, the health of the woman or her unborn child in ***serious*** jeopardy;
- ***Serious*** impairment to bodily functions; or
- ***Serious*** dysfunction of any bodily organ or part.

Emergency transportation and related emergency services provided by a licensed ambulance service are also covered benefits. 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:**

If you experience a condition requiring emergency services, you should attempt to seek medical care from the most readily available source. In such cases, you should notify us or your PCP within 48 hours of receiving the care, or as soon as possible thereafter. Your PCP's phone number is on the front of your ID card. You can also get this phone number from us by calling our Member Service Department at 1-800/622-2843.

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

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

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

**Emergencies within our service area:** You should follow the steps described above; get medical care for yourself or the person who needs it first. You or a family member must contact your PCP as soon as possible, but within 48 hours unless it was not reasonably possible to do so.

**Emergencies outside our service area:** You should follow the steps described above; get medical care for yourself or the person who needs it first. You or a family member must contact your PCP as soon as possible, but within 48 hours unless it was not reasonably possible to do so.

| Benefit Description | You pay |
|---|---|
| **Emergency within our service area** | |
| • Emergency care at a doctor's office | $10 per office visit during normal office hours; $20 per office visit after hours usually scheduled for appointments. |
| • Emergency care at an urgent care center | $25 per visit; waived if we authorize your admittance. |
| • Emergency care as an outpatient or inpatient at a hospital, including doctors' services | $25 per visit; waived if we authorize your admittance. |
| *Not covered: Elective or non-emergency care* | *All charges when we do not prior authorize your treatment.* |
| **Emergency outside our service area** | |
| • Emergency care at a doctor's office<br>• Emergency care at an urgent care center<br>• Emergency care as an outpatient or inpatient at a hospital, including doctors' services | Same as for Emergency within our service area. |
| *Not covered:*<br>• *Elective care or non-emergency care*<br>• *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*<br>• *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* | *All charges when we do not prior authorize your treatment.* |
| **Ambulance** | |
| Professional ambulance services when medically appropriate. These include, but are not limited to:<br>• Air ambulance<br>• Basic life support<br>• Advanced live support<br>• Invalid coach service<br>See 5(c) for non-emergency service. | You pay nothing when we authorize your treatment. |
| *Not covered: ambulance services when not medically necessary or not authorized by us.* | *All charges.* |

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

IMPORTANT

**Here are some important things to keep in mind about these benefits:**

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR AUTHORIZATION FOR CERTAIN SERVICES.** See the instructions after the benefits description below.

IMPORTANT

| Benefit Description | You pay |
|---|---|
| **Mental health and substance abuse benefits** | |
| All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.<br><br>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. | Your cost sharing responsibilities are no greater than for other illnesses or conditions. |
| • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers<br>• Medication management | $10 per office visit. |

*Mental health and substance abuse benefits - Continued on next page*

| Mental health and substance abuse benefits *(Continued)* | You pay |
|---|---|
| • Diagnostic tests | Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.<br><br>$10 per office visit if you must have an office visit to receive these services. |
| • Services provided by a hospital or other facility<br>• Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment | Nothing when we prior authorize your treatment. |
| *Not covered: Services we have not approved.*<br>*Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.* | *All charges.* |

**Prior Authorization.** To be eligible to receive these mental health and substance abuse benefits you must obtain a treatment plan and follow all of our network authorization processes. Your mental health and/or substance abuse treatment is provided through a subcontract with Magellan Behavioral Health, a behavioral health managed care company. Magellan Behavioral Health maintains a network of qualified mental health care professionals who offer care to our members. You are eligible for a full range of services including inpatient care, partial hospital programs, outpatient treatment and other levels of care appropriate to individual needs. Typically, a copayment of $10 for each outpatient counseling visit is required.

**Contacting Your Mental Health Provider**. A certain mental health provider group is assigned to the PCP you selected. If you need mental health and/or substance abuse services, you may contact your assigned mental health provider group directly and schedule an appointment (no PCP referral form is needed). If the outpatient non-emergency services you receive are not from the mental health provider group assigned to your PCP, these services will NOT be covered. If faced with a crisis, call your assigned mental health provider group, or contact Magellan Behavioral Health at 800/688-1911 (TDD number at 800/409-8640). The Magellan Behavioral Health Care Management Team and your mental health care provider are available 24-hours a day, seven days a week, to offer assistance and coordinate care. You may contact your PCP or KHP Central's Member Service Department at 1-800/622-2843 toll-free (TDD number at 1-800/669-7075) or Magellan Behavioral Health at 1-800/688-1911 (TDD number at 1-800/409-8640) to find out which Mental Health provider group is assigned to your PCP. Magellan Behavioral Health also offers translator services to its non-English speaking members. To access this service, call Magellan Behavioral Health at 1-800/874-9426. The mental health provider group will be responsible for providing and/or coordinating your mental health/substance abuse treatment.

**Inpatient Services - Mental Health or Substance Abuse.** If a need for inpatient care is identified, the inpatient stay must be prior authorized by Magellan Behavioral Health. Magellan Behavioral Health must prior authorize all non-emergency inpatient services.

**Emergency Services.** Emergency services do not have to be prior authorized but you or your family should contact us or Magellan Behavioral Health within 48 hours of receiving these services unless it is not reasonably possible to do so.

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

## Section 5 (f). Prescription drug benefits

I M P O R T A N T

**Here are some important things to keep in mind about these benefits:**

- We cover prescribed drugs and medications, as described in the chart beginning on page 42.
- 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 costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

I M P O R T A N T

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

- **Who can write your prescription.** A plan physician or a physician to whom you have been referred must write the prescription.

- **Where you can obtain them.** You have the option of going to any participating pharmacy or using the mail order pharmacy. At a participating pharmacy, simply show your Keystone Health Plan Central ID card when you present your prescription and you pay only the amount of the copayment or coinsurance specified by your KHPC prescription drug benefit. If, for any reason, the participating pharmacy is unable to process your prescription, you may need to pay the full cost of the prescription. You may then submit a member direct submission form to Express Scripts, our Pharmacy Benefits Manager (PBM), for reimbursement of the cost, less the amount of your copayment or coinsurance. All member direct submission forms must be submitted within 90 days of the date on the pharmacy receipt. You can get a member direct submission form by calling our Member Service Department at 1-800/622-2843.

  Prescription mail order service is provided through the Express Scripts mail order pharmacy. Using the mail order pharmacy for maintenance (long-term use) drugs that are taken for chronic conditions helps save you time and money by having drugs delivered directly to your home. You can purchase up to a 90-day supply of drugs at one time by paying your applicable mail order copayment or coinsurance for each prescription. You can obtain an Express Scripts mail order pharmacy packet by calling our Member Service Department at 1-800/622-2843.

  If you go to a non-participating pharmacy, you are responsible for paying the full cost for your prescription at the time of service. Only in the case of an emergency will reimbursement be considered for a prescription filled at a non-participating pharmacy. If this situation occurs, please submit a letter of explanation, along with your receipt, to Keystone Health Plan Central at the following address: **Keystone Health Plan Central Member Service Department, P.O. Box 898880, Camp Hill, PA, 17089-8880.** If after reviewing your request, Keystone Health Plan Central agrees that the situation was an emergency, you will be reimbursed, less your copayment or coinsurance, for the cost of the prescription drug. You must submit your receipt within 90 days of the pharmacy receipt to be considered for reimbursement.

- **We use a formulary.** Keystone Health Plan Central uses a drug formulary to help manage your prescription drug benefit. Under our formulary, selected classes of drugs have coverage limited to listed formulary drugs. Non-formulary drugs are not eligible for coverage; however, we have a non-formulary consideration process whereby your physician may request that coverage be granted when medically necessary. We encourage you to contact your physician to discuss your current medication and the appropriateness of a formulary alternative medication. If you have questions about which prescription drugs are on the formulary or about the non-formulary consideration process, or if you would like to request a copy of our Formulary, call our Member Service Department at 1-800/622-2843. Updates to the formulary will be reported to you in ***Keeping Well***, our quarterly member newsletter. You can also find information about our prescription programs on our website at www.khpc.com. We use a generic program to encourage or enhance the use of generic drugs. See the next section for more information on this.

- **These are the dispensing limitations.** You must purchase an FDA A-rated generic drug whenever one is available or you will be asked to pay an additional cost. If your Plan PCP or specialist writes a prescription for a name brand drug, or if you request a name brand drug, when an A-rated generic drug is available, **you pay** the $10, $20 or $30 copay plus the difference in cost to the Plan between the name brand drug and the A-rated generic drug, up to the original cost of the name brand drug. You can best utilize the mail order program by purchasing maintenance drugs taken for chronic conditions. You will receive instructions with each order explaining how to reorder your drug. If you attempt to fill your mail order prescription before the refill date on your most recent order, you will receive a notice telling you that you requested a refill too soon. You will have to contact Express Scripts to have your reorder processed after the appropriate amount of time has passed. You can request that your prescription be refilled after approximately 60% of the quantity has been used or approximately 54 days have elapsed since your last mail order prescription was filled.

- **Why use generic drugs?** All drugs have a generic or chemical name. When a company first develops a new drug, it gives the drug its brand name as part of its marketing plan. The FDA (Food and Drug Administration) regulates generic drugs in the same way they approve and regulate brand name drugs. Generic drug makers must prove to the FDA that the active ingredients in the generic drug have the same medical effect as its brand-name counterpart and must contain equal amounts of the same active ingredients, in the same dosage.

  The key to the effectiveness of a drug - either brand-name or generic - are its active ingredients. Its inactive ingredients determine the size, shape and color of a particular drug. Inactive ingredients, like dyes, fillers and preservatives, do not affect the way the active ingredients work. These inactive ingredients often make generic drugs look different from their brand-name counterparts.

  Developing new drugs is expensive. Companies that develop new drugs are given patent protection for the drug. Patents for new drugs usually last for 20 years. Upon expiration, other companies can produce the generic drug. These companies do not have to spend as much money researching and developing the generic drug as was needed to originally develop the drug. This enables companies to produce generic drugs at a lower cost.

  The price of a generic drug can be 15 to 80 percent less than its brand-name equivalent. These savings help keep your benefit costs lower. Unlike other generic products, generic drugs are strictly regulated for quality and consistency. Some people think that lower-priced generic drugs lack quality. This is not true. Nearly half of all brand-name drugs have a generic counterpart. However, since generic drugs aren't available until a drug's patent has expired, some drugs are only available as a brand-name from a single manufacturer.

  When your doctor writes a prescription, ask him/her to sign the prescription to allow for generic substitution. All 50 states have laws allowing your pharmacist - with your doctor's approval - to dispense generic drugs for prescriptions written for the brand-name drug. As always, if you have any questions, ask your doctor or pharmacist.

- **Some drugs require prior authorization.** The Plan has a Prior Authorization process in place through the Prescription Benefit Manager, Express Scripts, to review requests for certain drugs and compare them with clinical protocol for appropriateness. Drugs will generally be approved for a one-year period of use and authorized through the Express Scripts clinical team, comprised of clinical Pharmacists and physicians. Delays may occur in receiving these drugs to allow for clinical review of Provider submitted information. Questions regarding which drugs require Prior Authorization may be directed to the Plan's Member Service Department at 1-800-622-2843. Additionally a listing of drugs requiring Prior Authorization is available on Keystone Health Plan Central's website at www.khpc.com. Updates to the Prior Authorization list will be reported to members in Keystone Health Plan Central's quarterly member newsletter.
  If your medication requires prior authorization, your doctor may either call Express Scripts at 1-800-889-0376 or fax for review a completed Prescription Prior Authorization Form, along with any supporting

documentation, to Express Scripts at 1-952-893-4581. You or your doctor can download a Prescription Prior Authorization Form from our website at www.khpc.com.

If you are given a prescription for a prior authorized medication and try to obtain the drug at the pharmacy without a prior authorization, your doctor will receive a phone call from the pharmacist and/or PBM to obtain the information. Therefore, it will be more convenient for you and your doctor to provide this information in advance. An Express Scripts clinical review panel, consisting of clinical pharmacists and review associates, considers medication requests. If necessary, the reviewers will contact your doctor to clarify information provided on the Prescription Prior Authorization Form. Applying specific prior authorization criteria, the reviewer will determine if the request is approved or denied within two (2) working days from the date Express Scripts receives all of the applicable information.

If the medication is authorized, the requestor (the prescribing physician and/or dispensing pharmacy) will be notified (via phone or fax) of the decision within one (1) working day of making the decision. Up to a one-year authorization will be granted for the medication with each subsequent one-year authorization effective with a new prior authorization approval.

If the medication is denied, the requestor (prescribing physician and/or dispensing pharmacy) will be initially notified (via phone or fax) of the decision within one (1) working day of making the decision. The denial decision, including appeal information, will also be confirmed and communicated in writing to you, with carbon copy (cc) forwarded to the prescribing physician and to us within two (2) working days of making the decision. You and/or the prescribing physician, **with your written consent**, may file a grievance. See page 50 of this brochure for information on filing a grievance with us.

*Prescription drug benefits begin on the next page.*

| Benefit Description | You pay |
|---|---|
| **Covered medications and supplies** | |
| We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:<br><br>• Formulary drugs on the Keystone Health Plan Central Formulary<br>• Drugs for which a prescription is required by State or Federal law<br>• Insulin<br>• Diabetic supplies including alcohol wipes/pads, syringes, needles, glucose test strips, lancets, and one (1) blood glucose monitor in a calendar year<br>• Compounded preparations containing at least one formulary drug that requires a prescription<br>• Contraceptive drugs and devices<br>• Disposable needles and syringes for the administration of covered medications<br>• Oral chemotherapy | At a participating Plan pharmacy:<br><br>A $10 copay for up to a 30-day supply per prescription unit or refill;<br><br>A $20 copay for up to a 60-day supply per prescription unit or refill;<br><br>A $30 copay for up to a 90-day supply per prescription unit or refill.<br><br>From the Express Scripts mail order pharmacy program:<br><br>A $20 copay for up to a 90-day supply per prescription unit or refill.<br><br>Note: If there is a generic equivalent available and if you or your Plan doctor request a name brand drug, you will still have to pay the copay plus the difference in cost between the name brand and the generic drug, up to the original cost of the name brand drug. |
| • Drugs for sexual dysfunction are subject to dose or quantity limitations. Call the Plan for specific limitations.<br>• Oral medications for infertility treatment can be purchased from a participating Plan pharmacy or by mail order. Quantities are limited to a maximum of a 90-day supply.<br><br>NOTE: Oral medications used to treat infertility are covered as long as infertility is not due, in part or in its entirety, to either party (whether a KHPC member or not) having undergone a voluntary sterilization procedure and/or reversal of the voluntary sterilization procedure that was not successful. | 50% coinsurance. |

| **Covered medications and supplies** *(continued)* | **You pay** |
|---|---|
| *Not covered:*<br>• *Drugs that do not legally require a written prescription from a health care professional licensed to prescribe drugs (other than insulin)*<br>• *Drugs that have an over-the-counter (non-prescription) equivalent*<br>• *Nutritional or dietary supplements including vitamins and nutritional supplements available without a prescription*<br>• *Medical supplies such as dressings and antiseptics, except diabetic supplies as indicated on the benefit list*<br>• *Drugs and supplies for cosmetic purposes*<br>• *Drugs to enhance physical or athletic performance*<br>• *Drugs to promote weight loss, except for treatment of morbid obesity*<br>• *Drugs which are investigational or experimental in nature, as determined by Keystone Health Plan Central in accordance with this Program*<br>• *Venom and desensitization serums*<br>• *Smoking Cessation drugs and products*<br>• *Dental washes and rinses*<br>• *Replacement prescription resulting from loss, theft, or damage*<br>• *Except in emergency situations, drugs purchased from a non-participating pharmacy*<br>• *Request for reimbursement filed more than ninety (90) days after the pharmacy receipt* | *All Charges.* |

## Section 5 (g). Special Features

| Feature | Description |
|---|---|
| **Away From Home Care-Urgent** | If you are traveling outside the Plan's service area and require urgent care, you need to use the following procedure:<br>• Contact the 24-hour, toll-free provider locator service at 1-800-810-2583 or log on to www.bcbs.com.<br>• You will receive information regarding three available local providers (names, addresses, phone numbers, and directions) who can meet your medical needs.<br>• You will need to select a provider and schedule your own appointment.<br>• At the appointment, you must present your Plan Medical ID card and pay the applicable copayment while you are at your appointment.<br>• You must contact your Primary Care Physician to advise the office of your need for medical attention and coordinate any necessary follow up care.<br><br>**In the event of an Emergency:** The member seeks immediate assistance at the nearest medical facility. The member must contact his or her Primary Care Physician within 48 hours. |
| **Away From Home Care-Guest Membership** | If you will be out of the area for an extended period, such as a child at an out of area college, you may wish to enroll in our guest membership program as described below. Guest memberships give you and your dependents coverage (similar to that provided by KHPC) at the Blue Cross/Blue Shield HMO in that particular geographic area. You will have a Primary Care Physician (PCP) at the guest HMO, just like you did through KHPC. Essentially, you are covered under two plans at the same time, with no additional cost to you. When could a guest membership work for you or your family members? If your away-from-home travel is more extensive than day trips or week vacations, a guest membership may be the answer you are looking for. Members who take extended business trips (three to six months), students at college, or families living apart may all take advantage of the benefit of a guest membership.<br>To find out if you or your Dependents are eligible for the Guest Membership Program, please call KHP Central's Member Service Department at **1-800/622-2843** toll-free (TDD number at **1-800/669-7075** for the hearing impaired).<br>Please note that if you will be out of our service area for greater than six months or if you change your permanent residence to an address outside of the service area, you will not be eligible for the Guest Membership program. |
| ***Keeping Well*** | You will receive KHPC's member newsletter four times each year, keeping you updated on health-related topics of seasonal interest as well as informing you of updates to your coverage with us. |
| **HealthLink** | You will have easy access to health information whenever you need it, 24 hours a day, 365 days a year. This is an over-the-phone audio system giving you access to over 1,000 health related topics. |
| **www.khpc.com** | You can search our provider directory for participating doctors, hospitals and pharmacies, ask us questions, obtain information about our drug formulary, obtain various forms, read about our health management and educational programs or link to other health care-related sites. |

# Section 5 (h). Dental benefits

| | | |
|---|---|---|
| I M P O R T A N T | **Here are some important things to keep in mind about these benefits:**<br>• 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.<br>• Plan doctors must provide or arrange your care.<br>• We have no calendar year deductible.<br>• We cover hospitalization for dental procedures only when certain nondental physical impairments exist which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.<br>• Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. | I M P O R T A N T |

| Accidental injury benefit | You pay |
|---|---|
| We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. You must seek treatment within 24 hours of the accident, unless it is not feasible due to medical conditions. We do not cover accidental injuries due to chewing, biting or injuries resulting from dental disease. | Nothing |

## Dental benefits

We have no other dental benefits.

# 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 out-of-pocket maximums.

## Vision Care Discount Programs:

You are eligible to receive discounts at certain vision centers within our service area. Details can be found in the Eyecare Discounts section of our Plan's provider directory. You must show your Plan identification card to obtain these services.

## Fitness Discount Programs:

You are eligible for discounts at area health clubs, nicotine cessation programs and weight reduction programs. You can find a list in the Wellness Services section of our Plan's provider directory. You must show your Plan identification card to obtain these services.

# 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 doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *Services Requiring Our Prior Approval*** on pages 12-14.

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

# 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 and hospital benefits

In certain instances, you may be asked to pay for medical services or supplies at the time of service. This most commonly occurs with emergency services outside of the service area. For out-of-area emergency services, your KHPC identification card has national recognition because of our licensure with the Blue Cross and Blue Shield Association. However, we cannot ensure that all out-of-area hospitals and physicians will bill us directly. You can direct the physician or hospital to call the toll-free number on the reverse side of your identification card if they have questions about your health plan. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form.

When you must file a claim – such as for out-of-area care – submit it on the HCFA-1500 form or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- 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: Keystone Health Plan Central, P.O. Box 898880, Camp Hill, PA 17089-8880.**

### Prescription drugs

You may be asked to pay more than your copay for prescription drugs in an emergency situation. If you must file a claim for prescription drugs, contact us at 800/622-2843 and we will help you. You must request any reimbursement within 90 days of the pharmacy receipt.

**Submit your claims to: Keystone Health Plan Central, P.O. Box 898880, Camp Hill, PA 17089-8880**

### Deadline for filing your claim

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

### When we need more information

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

# 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:

| Step | Description |
|---|---|
| 1 | Ask us in writing to reconsider our initial decision. You must:<br>(a) Write to us within 6 months from the date of our decision; and<br>(b) Send your request to us at: Keystone Health Plan Central, FEP Denial Reconsideration Committee, P.O. Box 890163, Camp Hill, PA 17089-0163; and<br>(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and<br>(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 | We have 30 days from the date we receive your request to:<br>(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or<br>(b) Write to you and maintain our denial -- go to step 4; or<br>(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 | 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.<br>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.<br>We will write to you with our decision. |
| 4 | If you do not agree with our decision, you may ask OPM to review it.<br>You must write to OPM within:<br>• 90 days after the date of our letter upholding our initial decision; or<br>• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or<br>• 120 days after we asked for additional information.<br>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630. |

Send OPM the following information:

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

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

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

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

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

**6** 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, supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior authorization, then call us at 800/622-2843 (TDD number 800/669-7075) and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior authorization, 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 can call OPM's Health Benefits Contracts Division 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 are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

Medicare has two parts:

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

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

### • The Original Medicare Plan

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

Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must be authorized by your Plan PCP and we will not waive any of our copayments or coinsurance.

**(Primary payer chart begins on next page.)**

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

| **Primary Payer Chart** | | |
|---|---|---|
| **A. When either you -- or your covered spouse -- are age 65 or over and …** | **Then the primary payer is…** | |
| | **Original Medicare** | **This Plan** |
| 1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability), | | ✓ |
| 2) Are an annuitant, | ✓ | |
| 3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB or | ✓ | |
| b) The position is not excluded from FEHB (Ask your employing office which of these applies to you.) | | ✓ |
| 4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge), | ✓ | |
| 5) Are enrolled in Part B only, regardless of your employment status, | ✓ (for Part B services) | ✓ (for other services) |
| 6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty, | ✓ (except for claims related to Workers' Compensation.) | |
| **B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…** | | |
| 1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD, | | ✓ |
| 2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD, | ✓ | |
| 3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision, | ✓ | |
| **C. When you or a covered family member have FEHB and…** | | |
| 1) Are eligible for Medicare based on disability and, a) Are an annuitant, or | ✓ | |
| b) Are an active employee, or | | ✓ |
| c) Are a former spouse of an annuitant, or | ✓ | |
| d) Are a former spouse of an active employee | | ✓ |

*Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.*

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

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

- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800/622-2843.

We do not waive any costs when you have Medicare.

**• Medicare managed care plan**

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

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

**This Plan and our Medicare managed care plan:** You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB coverage.

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

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

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

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

## TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

## Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

## Medicaid

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

## 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 page 15.

**Copayment**

A copayment is a fixed amount of money you pay when you receive covered services. See page15.

**Covered services**

Care we provide benefits for, as described in this brochure.

**Custodial care**

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities.

**Experimental or investigational services**

We rely on available, credible data and on the advice of the general medical community. The general medical community includes, but is not limited to, medical consultants, medical journals and governmental regulations. The data from these sources is used to determine if any treatment, procedure, facility, equipment, drug, drug application, drug usage device, or supply is not accepted as standard medical treatment for the condition being treated. The data is also used to determine if any such items that require Federal or other governmental agency approval were not granted such approval at the time the services were rendered or requested.

**Group health coverage**

Health coverage you receive from this Plan when you join through the FEHBP.

**Medical necessity**

Services or supplies provided to you by a health care provider that we determine are:

- Appropriate and necessary for the diagnosis and/or the direct care and treatment of your medical condition, disease, illness or injury; and are essential for improving and/or maintaining your current health status;
- In accordance with accepted standards of good medical practice;
- Consistent with our protocols and utilization guidelines;
- Not primarily for your convenience and/or that of your family, physician or other health care provider; and
- Provided at the most appropriate level of service, setting or supply necessary to safely diagnose or treat you. When applied to Hospital Services, this further means that you require care in an emergency room or as an Inpatient due to your symptoms or condition, and that you cannot receive safe or adequate care as an Outpatient in another setting.

**Us/We**

Us, we and KHPC refer to Keystone Health Plan Central and our affiliated providers.

**You**

You refers to the enrollee and each covered family member.

# Section 11. FEHB facts

## No pre-existing condition limitation

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

## Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. 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:

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

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

## Types of coverage available for you and your family

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

## When benefits and premiums start

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

## Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

## When you retire

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

## When you lose benefits

**• When FEHB coverage ends**

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

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

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

**• Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. 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.

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

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

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

**Enrolling in TCC.** Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. 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 website (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

## Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

**The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:**

**What is long term care (LTC) insurance?**

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

**I'm healthy. I won't need long term care. Or, will I?**

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many people now consider long term care insurance to be vital to their financial and retirement planning.*

**Is long term care expensive?**

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

**But won't my FEHB plan, Medicare or Medicaid cover my long term care?**

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

**When will I get more information on how to apply for this new insurance coverage?**

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

**How can I find out more about the program NOW?**

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

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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 Keystone Health Plan Central- 2002

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

| Benefits | You Pay | Page |
|---|---|---|
| Medical services provided by physicians:<br>• Diagnostic and treatment services provided in the office .................. | Office visit copay: $10 primary care; $10 specialist | 16 |
| Services provided by a hospital:<br>• Inpatient.......................................................<br>• Outpatient...................................................... | Nothing<br>Nothing | 31<br>32 |
| Emergency benefits:<br>• In-area ..........................................................<br>• Out-of-area ...................................................... | $25 per emergency room visit<br>$25 per emergency room visit | 35<br>35 |
| Mental health and substance abuse treatment ......................................... | Regular cost sharing | 36 |
| Prescription drugs..........................................................<br><br>For up to a 90-day supply per prescription unit or refill for generic drugs or name brand drugs | At a participating retail pharmacy:<br><br>$10 copay per 30-day supply<br><br>$20 copay per 60-day supply<br><br>$30 copay per 90-day supply | 39 |
| Dental Care..........................................................<br><br>We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. | Nothing | 44 |
| Vision Care.......................................................... | No benefit. | 23 |
| Special features: Away From Home Care-Urgent; Away From Home Care-Guest Membership; *Keeping Well;* HealthLink; and www.khpc.com. | | 43 |
| Protection against catastrophic costs (your out-of-pocket maximum) ................................................ | We do not have an out-of-pocket maximum | 14 |

# 2002 Rate Information for
# KEYSTONE HEALTH PLAN CENTRAL

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

**Postal rates** apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses, RI 70-2B; and 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.

| | | Non-Postal Premium | | | | Postal Premium | |
|---|---|---|---|---|---|---|---|
| | | Biweekly | | Monthly | | Biweekly | |
| **Type of Enrollment** | **Code** | **Gov't Share** | **Your Share** | **Gov't Share** | **Your Share** | **USPS Share** | **Your Share** |
| **Self Only** | **S41** | **$97.86** | **$47.33** | **$212.03** | **$102.55** | **$115.52** | **$29.67** |
| **Self and Family** | **S42** | **$223.41** | **$127.89** | **$484.06** | **$277.09** | **$263.75** | **$87.55** |