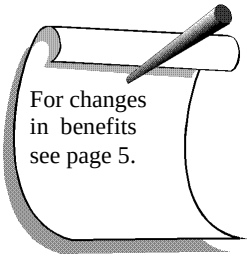
Keystone Health Plan Central 2000

A Health Maintenance Organization



Serving: The Lehigh Valley, Northern Tier and Harrisburg, Pennsylvania areas

Enrollment in this Plan is limited; see page 6 for enrollment requirements.

Enrollment code:

S41 Self only

S42 Self and family

This Plan has full accreditation with a ranking of "Commendable" from the NCQA. See the *2000 Guide* for more information on NCQA.

Visit the OPM website at http://www.opm.gov/insure
and
our website at http://www.khpc.com

Authorized for distribution by the:

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE

Federal Employees Health Benefits Program

RI 73-241

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Introduction

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

This brochure describes the benefits you can receive from Keystone Health Plan Central under its contract (CS 2076) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 5. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Keystone Health Plan Central as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.

3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.

4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.

7. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.

8. FEHB FACTS. Read this for information about the Federal Employees Health Benefits (FEHB) program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services from non-Plan providers, you may have to pay for the services and submit itemized bills and your receipts to the Plan with an explanation of the services and the identification information from your ID card.

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 or group of physicians, hospital, or other provider will be available and/or remain under contract with us. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program (See Section 3, How to get benefits, for more information).

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

Your share of Keystone Central Health Plan's non-postal premium will increase by 17.1% for Self Only or 13.9% for Self and Family.

Mental Health/Substance Abuse: Outpatient Mental Health Benefits have been enhanced to include up to 60 outpatient visits per calendar year for serious mental illness, subject to a $25 copayment per visit. Inpatient Mental Health Benefits have been enhanced to include up to 30 days per calendar year for serious mental illness. Unused calendar inpatient days may be exchanged on a one-for-two basis to secure additional outpatient benefits.

Diabetic Supplies**:** Coverage has been enhanced for equipment, supplies, training and education for diabetics (non-insulin dependent as well as insulin dependent). Equipment and supplies include such items as blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics. Members can obtain Diabetic Supplies such as needles, syringes, lancets, test strips, and alcohol wipes/pads with any diagnosis of diabetes through the Prescription Drug benefit (prescription is required to an Express Scripts/Value Rx pharmacy and copayments apply without reimbursement option). (Insulin Infusion devices and orthotics for diabetics maybe obtained through a Keystone Health Plan Central participating Durable Medical Equipment supplier with a referral.) Any equipment to exceed $100 requires prior authorization from the plan.

Diabetic Eye exam**:** Diabetes, particularly diabetic retinopathy, is the leading cause of adult blindness. Detection and early treatment are important in preventing loss of vision. In an effort to improve care and to encourage members with diabetes to have a yearly eye examination, Keystone Health Plan Central will allow diabetic members one yearly self-referral for a diabetic retinopathy screening to a Keystone Health Plan Central participating ophthalmologist or optometrist, and any applicable copayment will be waived for that visit. Refractions remain a non-covered service and any such charges incurred are the responsibility of the member. All eligible diabetic members will be sent a letter each calendar year that they must take to the appointment with the participating eye specialist.

Section 3. How to get benefits

What is this Plan's service area?

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is:

Lehigh Valley: The Pennsylvania counties of Lehigh and Northampton

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

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.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas.

As a Keystone Health Plan Central member, you have access to physician care for urgent medical situations when you are away from home through HMO Blue USA, a nationwide network of Blue Cross and Blue Shield HMOs. HMO Blue USA is one of the largest HMO networks in the country, offering coverage in more than 200 cities. If you become ill while visiting one of these cities, contact the HMO Blue USA network at 1-800-4HMO-USA. This number is also found on the back of your ID card. The HMO Blue USA referral coordinator will schedule an appointment with an HMO Blue USA physician in the area from which you are calling. No office visit copayments will be required and you will not need to file a claim.

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 HMO Blue USA Guest Membership Coordinator.

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.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services. Your out-of-pocket expenses are limited to the copayments stated in this brochure.

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

Keystone Health Plan Central is an Individual Practice Prepayment (IPP) Plan. Each member selects a primary care physician (PCP) from among the Plan's participating Family Practitioners, Internists, and Pediatricians. There are currently over 1,500 primary care physicians who participate in the plan.

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care. To be eligible for coverage, all hospital admissions must be prior authorized through Keystone Health Plan Central.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 800/622-2843 (TDD 1-800-669-7075 for the hearing impaired). If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist. 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. 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 prior to having services rendered to ensure that he or she has obtained the proper Prior Authorization from KHPC for the listed services.

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 Primary Care Physician 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 non-obstetrical, non-gynecological and non-Emergent 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, or other vendor we designate.

A particular Mental Health provider group is assigned to your PCP. You may contact your PCP or our Member Service Department at (717) 763-3894, or 1-800-622-2843 toll-free in Pennsylvania (TDD number at 1-800-669-7075 for the hearing impaired) or Magellan Behavioral Health at 1-800-688-1911 (TDD number at 1-800-409-8640 for the hearing impaired) 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 for the hearing impaired). 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.

If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan. The physician may have to get an authorization, or approval, beforehand. For Members who are afflicted with a life-threatening, degenerative or disabling disease or condition (as determined by KHPC) a standing referral may be given to a specialist with clinical expertise in treating the disease or condition or, in certain cases, a specialist may be designated to provide and coordinate the Member's primary and specialty care.

In order to obtain a standing referral, a referral form must be obtained from the Member's PCP. The referral form provides the specialist with the ability to perform the treatment required for a specific episode of illness, for up to 90 days. The specialist may refer the Member for additional services, including laboratory testing, radiology, diagnostic testing or Durable Medical Equipment (DME). Laboratory services must follow the PCP's laboratory arrangement as indicated on the referral form and the Member's identification card. At the end of the 90-day period, the Member must return to the PCP for an additional Referral form according to his or her treatment plan. If the specialist deems that the referral form should be extended without a visit to the PCP, he or she may do so in consultation with the PCP. Please note that all prior authorization guidelines will still apply.

Designations of specialists to provide and coordinate the Member's primary and specialty care must be requested in writing and shall be approved pursuant to a treatment plan approved by KHPC in consultation with you, your PCP and, as appropriate, the Specialist.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide 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.

What do I do if my 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.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is:

1) Appropriate, and necessary, for the diagnosis and/or treatment of your medical condition, disease, illness or injury; and is essential for improving and/or maintaining your current health status;
2) in accordance with accepted standards of good medical practice;
3) consistent with KHPC's or its designee's clinical protocols and utilization guidelines;
4) not primarily for the convenience of you, your family, or physician or other health care provider; and
5) 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 the you require care in an emergency room or as an inpatient due to the symptoms presented or your condition, and you cannot receive safe or adequate care as an outpatient in another setting.

How do you decide if a service is experimental or investigational?

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 or 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.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing;
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information.

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us at 800/622-2843 (TDD number 1-800/669-7075 for the hearing impaired) and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contracts Division 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.

2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

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

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to OPM?

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

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

Medical and Surgical Benefits

What is covered?

Plan physicians and other Plan providers provide a comprehensive range of preventive, diagnostic and treatment services including all necessary office visits; **you pay** a $10 copay per visit. **You pa**y a $20 copay per visit for visits to a physician's office after normal hours. Within the service area, house calls will be provided if, in the judgement of the Plan doctor, such care is necessary and appropriate; **you pay** nothing for a physician's house call, or for home visits by nurses and health aides.

The following services are included, and are subject to the office visit copay unless otherwise indicated:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through 39, one mammogram during these five years; for women ages 40 and over, one mammogram every year. All female members age 40 and over may self-refer to a participating provider for an annual screening mammogram. In addition to routine screening, mammograms are covered when prescribed by the physician as medically necessary to diagnose or treat your illness.

- Routine immunizations and boosters (copayment waived for children up to age 18)
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor (office visit copayments are waived for obstetrical care). The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum); excluding poison ivy injections
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints; breast prosthesis and surgical bras, as well as their replacement. Cornea, heart, heart-lung, kidney, liver, lung (single or double), and pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Transplants are covered when approved by the Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Orthopedic devices, such as braces; foot orthotics
- Prosthetic devices, such as artificial limbs and intraocular lenses following cataract removal
- Standard durable medical equipment (DME), such as wheelchairs and hospital beds
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you.
- Home Health Care when provided by home health care personnel in the member’s home if located within the service area and referred by the PCP and prior authorized by KHPC. Private duty nursing will be covered only if specifically prior authorized. Homemaker services, and other non-medical
- services, are not covered.

Limited benefits

provided for non-dental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. The member is entitled to oral surgery services for the extraction of impacted teeth when partially or totally covered by bone. Such services must be recommended by an oral surgeon and approved by Keystone Health Plan Central. Services will be fully covered and may be provided to the member on an outpatient or, when medically necessary, inpatient basis.

Mastectomy and Breast Cancer Reconstructive Surgery is covered, including medically necessary hospitalization and home health care when a member is discharged within 48 hours following admission for a mastectomy. Coverage is provided for initial and subsequent artificial prosthetic devices inserted during reconstructive surgery and for all stages of mastectomy, including lymphedemas, which are pursuant to an order of the participating physician. Coverage for reconstructive surgery to be performed on one or both breasts following a mastectomy to re-establish symmetry or alleviate functional impairment as a result of the mastectomy is also covered. Coverage for prosthetic devices inserted during reconstructive surgery and reconstructive surgical procedures themselves are limited to such procedures performed within six years of the date of the mastectomy.

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

Short-term rehabilitative therapy (physical, speech, occupational, orthoptic, cardiac, respiratory and urinary incontinence therapy) is provided on an inpatient or outpatient basis for up to 60 consecutive days per condition if significant improvement can be expected based on the treatment plan prescribed; **you pay** nothing. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Infertility counseling, testing, and services, including artificial insemination, but excluding in-vitro fertilization, will be covered when prior authorized by KHPC. Infertility services are subject to a copayment of 50% of the cost of treatment, which includes the cost of injectables related to infertility services administered and/or dispensed by the physician's office. Infertility services are available to both male and female members. Infertility services are not covered if the present condition of infertility is due, whether wholly or partially, to either party having undergone a voluntary sterilization procedure and/or an unsuccessful reversal of a voluntary sterilization procedure, whether either party is a KHPC member or not. Other services that are not covered under infertility are: cost of donor sperm, reversal of voluntary sterilization and embryo transfer.

Chiropractic services are limited to acute care (severe and sudden onset within 1 week of the accident or injury) and are provided for up to two weeks. Services are limited to X-rays, consultations and manipulation. Chronic problems and routine maintenance are not covered.

Oral and maxillofacial surgery is

What is not covered?

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Blood and blood derivatives not replaced by the member
- Hearing aids
- Long-term rehabilitation services
- Homemaker services
- Eye exercises and eyeglasses, contact lenses or the fitting of contact lenses
- Refractions, including lens prescriptions
- Charges for missed appointments and charges for completion of insurance forms
- Radial keratotomy

Hospital/Extended Care Benefits

What is covered?

Hospital Care

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

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

Extended Care

The Plan provides a comprehensive range of benefits with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. You pay nothing. All necessary services are covered, including:

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

Hospice Care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility up to a maximum of $7500. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of the Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance Service

Medically necessary ambulance services are covered when required in connection with emergency services or when ordered or referred by the primary care physician and prior authorized by KHPC or its designee in connection with non-emergency care.

Limited Benefits

Inpatient dental procedures

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

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See pages 20-21 for non-medical substance abuse benefits.

What is not covered?

- Personal comfort items, such as telephone and television
- Blood and blood derivatives not replaced by the member
- Custodial care, rest cures, domiciliary or convalescent care

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Emergency Benefits

What is a medical emergency?

An emergency service is any health care service provided 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:

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

Emergency transportation and related emergency services provided by a licensed ambulance service, shall also be considered emergency services.

Emergencies within the service area

In the event you experience a condition requiring Emergency Services, you should attempt to contact your PCP. If you cannot contact your PCP at the time of the injury or condition, you should seek medical care from the most readily available source. In such cases, you should notify your PCP or KHPC within 48 hours of receiving the care, or as soon as possible thereafter.

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

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

To be covered by this Plan, any

follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays…

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

You pay…

$25 per hospital emergency room visit or $25 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to the hospital, the emergency room copayment is waived.

Emergencies outside the service area

Emergencies outside the service area are subject to the ongoing Non-Participating Provider provisions set forth below, the charges for Medically Necessary Emergency Services received outside the service area are covered only if, in the determination of KHPC:

- You could not have anticipated the need for such services prior to leaving the service area, and
- Delaying the care until you could be expected to return to the care of the PCP might significantly jeopardize your health or life.

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

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

Plan pays…

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

You pay…

$25 per hospital emergency room visit or $25 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to the hospital, the emergency room copayment is waived.

What is covered?

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

What is not covered?

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

Filing Claims for Non-Plan Providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Claims for non-Plan Providers should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 11-14.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered?

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

- Diagnostic evaluation
- Psychological testing (brief testing to establish a diagnosis)
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to sixty (60) visits for Serious Mental Illness are covered per calendar year, when provided by a Participating Provider and determined to be Medically Necessary by KHPC or its designated agent and appropriate for short term evaluation and/or crisis intervention. In addition, unused calendar year Inpatient Serious Mental Illness days may be exchanged on a one-for-two basis to secure additional Outpatient visits for Serious Mental Health Illness. Outpatient Electro Convulsive Therapy will be counted against the patient's Inpatient mental health benefit on a one session for one Inpatient day basis. **You pay** a $25 copayment for each covered visit - all charges thereafter.

For other than Serious Mental Illness, up to twenty (20) Outpatient mental health care visits per calendar year, when provided by a Participating Provider and determined to be Medically Necessary by KHPC or its designated agent and appropriate for short-term evaluation and/or crisis intervention are covered. Outpatient Electro Convulsive Therapy will be counted against the patient's Inpatient mental health benefit on a one session for one Inpatient day basis. **You pay** a $25 copayment for each covered visit – all charges thereafter.

Inpatient care

For Serious Mental Illness, Medically Necessary Inpatient mental health care services in a Participating facility are covered. Benefit is limited to thirty (30) Inpatient days per Member in a calendar year. In addition, unused calendar year Inpatient Serious Mental Illness days may be exchanged on a one-for-two basis to secure additional Outpatient visits for Serious Mental Health Illness. Outpatient Electro Convulsive Therapy will be counted against the patient's Inpatient mental health benefit on a one session for one Inpatient day basis. **You pay** nothing for the first 30 days of hospitalization for serious mental illness – all charges thereafter.

For other than Serious Mental Illness, Medically Necessary Inpatient mental health care services in a Participating facility are covered. Benefit is limited to thirty (30) Inpatient days per Member in a calendar year. Outpatient Electro Convulsive Therapy will be counted against the patient's Inpatient mental health benefit on a one session for one Inpatient day basis. **You pay** nothing for the first 30 days of hospitalization for other than serious mental illness – all charges thereafter.

What is not covered?

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

Substance abuse

What is covered?

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

Alcoholism Benefits

Outpatient care

Up to 60 visits per calendar year for rehabilitation and counseling services; lifetime maximum of 120 visits. **You pay** nothing for the first course of treatment (course of treatment determined by Plan doctor); you pay a $25 copayment per full visit, a $15 copayment per partial visit during subsequent treatment courses - all charges after 60 visits per year or 120 per lifetime. Up to 30 outpatient visits per calendar year may be exchanged on a 2 for 1 basis to secure up to 15 additional non-hospital residential alcohol abuse treatment days, which are in addition to the annual and lifetime max.

Inpatient care

Up to 30 days per calendar year for rehabilitation services; lifetime maximum of 90 days. **You pay** nothing during benefit period - all charges thereafter.

Other Substance Abuse Benefits

Outpatient care

Up to 30 visits per calendar year for counseling and treatment; **you pay** a $25 copayment per visit for each covered visit- all charges thereafter.

Inpatient care

One 28 day confinement (up to 33 days if treatment includes detoxification) per calendar year for substance abuse rehabilitation; lifetime maximum of two confinements. **You pay** nothing during benefit period- all charges thereafter.

What is not covered?

- Rehabilitation services in an acute care hospital, except for alcohol abuse
- Treatment that is not provided by a Plan doctor or authorized by Magellan Behavioral Health or other vendor that we designate

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan Primary Care Physician (PCP), or a specialist to whom the PCP makes a referral, and obtained at a participating pharmacy, are dispensed for up to a 90-day supply. **You pay** a $10 copayment for up to a 30-day supply, or a $20 copayment for up to a 60-day supply, or a $30 copayment for up to a 90-day supply per prescription unit or refill for generic drugs or for brand name drugs when the prescribing doctor requires a brand name drug. A valid Plan ID card must be presented at the pharmacy when obtaining prescription drugs.

Mail Order: Prescription drugs may be obtained through the Plan's mail order pharmacy, and will be dispensed for up to a 90-day supply. **You pay** a $20 copayment per prescription unit or refill regardless of days supply.

Generic Enforcement: Generic drugs will be substituted for brand name drugs when permissible, whether obtained at a participating pharmacy or through the mail order pharmacy. If you request a brand name drug when generic substitution is permissible and the prescribing doctor does not require the brand name drug, **you pay** the $10 copayment plus the cost difference between the brand name drug and its generic equivalent.

Formulary: Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Non-formulary drugs will not be covered unless there is plan approval through the non-formulary consideration process.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Prescription contraceptive drugs and devices
- Insulin
- Diabetic supplies such as syringes, needles, glucose test strips, lancets, etc.
- Disposable needles and syringes needed to inject covered prescribed medication
- Compounded preparations containing at least one prescription drug

Limited benefits

Medications used to treat either infertility or sexual dysfunction will be dispensed subject to dose or quantity limitations. Call the Plan for specific limitations. Must be prescribed by Plan doctors and obtained at a participating pharmacy. **You pay** 50% of the cost.

What is not covered?

- Drugs available without a prescription or for which there is a non-prescription equivalent available
- Drugs obtained at a non-participating pharmacy except for emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs
- Weight control drugs
- Blood and blood products
- Dental applications including fluoride
- Venom and desensitization serums
-

Other Benefits

Dental care

Accidental injury benefit	Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for services must result from an accidental injury. Services must be sought within 24 hours of the accident unless it is not feasible, due to medical conditions, for services to be covered. **You pay** nothing. Accidental dental injuries caused by chewing are not covered

Non-FEHB Benefits Available to Plan Members

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

Vision Care

Various vision centers within our service area offer discounts to Keystone Health Plan Central Members. Details can be found in the Wellness Services and Eyecare Discounts section of the Participating Physicians, Pharmacies, and Hospitals Directory. Members should present their Plan identification card to obtain services.

Fitness Discount Programs

Area health clubs, smoking cessation programs and weight reduction programs offer discounts to Keystone Health Plan Central Members. Members will find a list of participating organizations in the Wellness Services and Eyecare Discounts section of the Participating Physicians, Pharmacies, and Hospitals Directory. Members present their Plan identification card to obtain discounts.

NurseLink

Keystone Health Plan Central is pleased to offer you a unique service that gives you access to professional health information whenever you need it - 24 hours a day, 7 days a week. NurseLink gives you access to a registered nurse, or to our health information library, which contains over 1,100 health-related topics. By using the NurseLink directory, you can hear pre-recorded information about many health topics by simply using 4-digit topic codes. Please call (717) 763-3894 or (800) 622-2843 (TDD number 1-800/669-7075 for the hearing impaired) for additional information about NurseLink.

NOTE: NurseLink is intended to be a resource for information that does not replace the care or advice of your physician. You should always contact your PCP immediately in an Urgent or Emergent medical situation.

KHPC offers several special "wellness" programs that are listed below. Information on any of these programs can be obtained by calling Member Services at (800) 622-2843 (TDD number 1-800/669-7075 for the hearing impaired.)

"Taking Lifetime Control" - Diabetes Program
"Special Deliveries" - High Risk Maternity Management Program
"Take AIM" - Asthma Program
"Gift of Good Health" - Mammography Management Program
"Free and Clear" - Smoking Cessation Program

Medicare + Choice prepaid plan enrollment

This plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 4, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare + Choice prepaid plan when one is available in their area. They may then later re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare + Choice prepaid plan but will probably have to pay for hospital coverage in addition to the Medicare Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changes to a Medicare + Choice prepaid plan. Contact us at (800) 990-4201 for information on the Medicare + Choice prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in a Medicare + Choice HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call (800) 990-4201 for information on the benefits under the Medicare + Choice HMO.

Benefits on these pages are not part of the FEHB contract

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 or condition.

We do not cover the following:

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

Section 7. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 23 (Plan specific).

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. 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 disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies
We do not cover services and supplies that a local, state, or Federal Government agency directly or indirectly pays for.

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 800/622-2843 (TDD number 1-800/669-7075 for the hearing impaired), or write to P.O. Box 898812, Camp Hill, PA 17089-8812. You may also contact us by fax at 717/972-0094, or visit our website at www.khpc.com.

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I 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, which is described later in this section.

What types of coverage are available for my family and me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who is incapable of self-support, which is also authorized by your employing or retirement office.

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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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. No new enrollment form is necessary.

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

Are my medical and claims records 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse 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 more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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.

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends;
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed;
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs;
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium;
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notifies your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

How can I get a Certificate of Group Health Plan 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. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.
If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

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 (TDD 1-800-669-7075 for the hearing impaired); and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Keystone Health Plan Central - 2000

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

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	16
	Extended care	All necessary services, no dollar or day limit. **You pay** nothing	16
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** nothing	19, 20
	Substance abuse	For alcoholism, up to 30 days per year for abuse rehabilitation, lifetime maximum of 90 days. For other substance abuse, one 28-day confinement per year for rehabilitation, lifetime maximum of two confinements. **You pay** nothing	20, 21
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** $10 per office visit, or $20 for house calls by a doctor	13
	Home health care	All necessary visits per calendar year by nurses and health aides. **You pay** nothing	14
	Mental conditions	Up to 60 outpatient visits per year. **You pay** a $25 copay per visit	19, 20
	Substance abuse	For alcoholism, up to 60 visits per year for rehabilitation, lifetime maximum of 120 visits; **you pay** nothing for the first course of treatment then a $25 copay per full visit or a $15 copay per partial visit. For other substance abuse, up to 30 visits per year. **You pay** a $25 copay per visit	20, 21
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $25 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan	17, 18
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $10 copay per prescription (generic or brand) (oral contraceptives included) per 30-day supply, generic enforcement, 3 times copay for 90-day supply. Mail order "maintenance" drugs (oral contraceptives included) 90-day supply, . generic enforcement. . . .	21, 22
Dental care		Accidental injury benefit; you pay nothing	22
Vision care		No current benefit	
Out-of-pocket maximum		Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for a few benefits	13

2000 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 most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees", RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	**S41**	**$78.83**	**$29.47**	**$170.80**	**$63.85**	**$93.06**	**$15.24**	**$93.26**	**$15.04**
Self and Family	**S42**	**$175.97**	**$86.32**	**$381.27**	**$187.03**	**$207.74**	**$54.55**	**$201.02**	**$61.27**