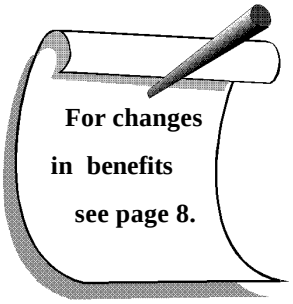
Keystone Health Plan Central 2003

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 2003 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

FEHB
Federal Employees Health Benefits Program

RI 73-241

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

(A) THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.

- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

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Introduction

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 Plan is underwritten by Keystone Health Plan Central. The address for Keystone Health Plan Central administrative offices is:
Keystone Health Plan Central
P.O. Box 898812
Camp Hill, PA 17089-8812

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" 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 20415-3650.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 1-800-622-2843 and explain the situation.
    - If we do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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.

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 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 a participating provider and us.
- 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 (TDD 1-800-669-7075), or write to Keystone Health Plan Central, Attn: Customer Service, P.O. Box 898880, Camp Hill, PA, 17089-8880. You may also contact us by fax at 717-302-0120, visit our website at www.khpc.com, or e-mail us at CustomerService@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 KHP Central at 1-800-622-2843 and ask to speak with the Guest Membership Coordinator.

Section 2. How we change for 2003

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

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will decrease by 0.9 % for Self Only or increase by 0.7 % for Self and Family.
- Your Prescription Drug Benefit copayment at a participating pharmacy will change to the following:
    - A $10 copayment for generic drugs for up to a 30-day supply or unit of use
    - A $25 copayment for preferred name brand drugs for up to a 30-day supply or unit of use
    - A $40 copayment for non-preferred name brand drugs for up to a 30-day supply or unit of use

  Your Prescription Drug Benefit copayment at the mail service pharmacy will change to the following:
    - A $20 copayment for generic drugs for up to a 90-day supply or unit of use
    - A $50 copayment for preferred name brand drugs for up to a 90-day supply or unit of use
    - A $80 copayment for non-preferred name brand drugs for up to a 90-day supply or unit of use
- Your provider must obtain prior approval for Durable Medical Equipment purchases with a cost of $250 or more per item.

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 (TDD 1-800-669-7075), write to us at P.O. Box 898880; Camp Hill, PA 17089-8880, or e-mail us at CustomerService@khpc.com. You may also request replacement cards through our website at www.khpc.com.

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 with whom we contract 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 Customer Service Department at 1-800-622-2843 (TDD 1-800-669-7075) to request a provider directory.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area with whom we contract 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 Customer Service Department at 1-800-622-2843 (TDD 1-800-669-7075) 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 (TDD 1-800-669-7075), e-mailing us at CustomerService@khpc.com, or search for a PCP on our website at www.khpc.com

- **Primary care**

Your primary care physician can be a general or 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. 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 referred you for a certain number of visits without additional referrals. The primary care physician must provide or refer 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 to the appropriate Participating Provider. Some services will also require prior authorization from KHP Central. If you wish to change the specialist to whom you have been referred, contact your PCP for a new referral.

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.

KHP Central also has a telephonic referral system which allows your PCP's office to issue a specialty care referral by telephone, eliminating the need for a paper referral. With the telephonic process, your referral will be entered into our system and a copy will be faxed to your PCP and your specialist. Please note that if your PCP uses the telephonic referral process you will not receive or require a hard copy of the referral.

Certain services require prior authorization by KHP Central'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 KHP Central 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 Plan 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, your PCP or KHP Central 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.

Oral Surgical Care. Services provided to you for the extraction of impacted teeth when partially or totally covered by bone do not require a referral from your PCP. You are permitted to contact your Plan Oral Surgeon directly and seek treatment. Please note that all prior authorization guidelines still apply.

Retroactive referrals are *not* permitted by KHP Central. You must obtain the referral before receiving services other than obstetrical, gynecological, oral surgical, or emergency services.

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

You must contact PacifiCare Behavioral Health (PBH) at 1-800-216-9748, (TDD number at 1-888-877-5378) to notify PBH of the need for services and to receive names of network providers who will best meet your needs. PacifiCare also offers translator services to its non-English speaking Members. To access this service, simply contact PacifiCare at 1-800-216-9748. The PBH Provider you choose will be responsible for providing and/or coordinating your mental health/substance abuse treatment.

If you receive outpatient non-emergency services from a non-PBH provider and without prior notification to PBH these services will NOT be covered. If you are faced with a crisis, contact PBH at 1-800-216-9748 (TDD number at 1-888-877-5378). PacifiCare Behavioral Health Care Management Team and network providers are available 24 hours a day, 7 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 Customer 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 inpatient facility admissions, including skilled nursing and rehabilitation
- Allergy - all allergy injections (except venom 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 clinical trials
- Cancer therapies (inpatient only)
- DME - all eligible rental items and/or all eligible purchased items with a cost of $250 or more per item
- Drug therapies prior authorized by KHP Central (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 – non-emergency services received in an emergency room setting
- 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
- Home health services - including home infusion, private duty nursing, and patient 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)
- Neuropsychological testing
- Non-contracted providers and/or out of network services
- Nuclear medicine
- Office surgical procedures - select office surgical procedures when performed outside the physician office setting:
    -- Arthrocentesis
    -- Aspiration of a joint
    -- Colposcopy
    -- Electrodessication condylomata - *complex*
    -- Excision of a chalazion
    -- Excision of a nail, partial or complete
    -- Excision of all types of benign lesions (under 2.0 cm diameter)
    -- External hemorrhoidectomy
    -- Injection of a ligament or tendon
    -- Oral surgery
    -- Pain management, including facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostal nerve blocks
    -- Proctosigmoidoscopy/Flexible sigmoidoscopy
    -- Removal of partial or complete bony impacted teeth
    -- Suture of uncomplicated wounds
    -- Vasectomy
    -- Wound care and dressings
- Pain Management – all pain management procedures when performed outside the physician office setting
- Rehabilitative therapies - all rehabilitative therapies, such as physical, occupational, speech, cardiac, respiratory, vision, and urinary incontinence
- Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)
- Surgeries - all outpatient facility based surgeries, including hospitals and ambulatory surgical centers (excluding endoscopic procedures except those listed in bulleted item 12)
- 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 emergency 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.
· **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	We do not have a catastrophic protection out-of-pocket maximum.

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 67 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 1-800-622-2843 (TDD 1-800-669-7075), at our website at www.khpc.com, or e-mail us at CustomerService@khpc.com.

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- Vision services (testing, treatment, and supplies)
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Section 5 (a) Medical services and supplies 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 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

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

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • 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. $10 per office visit if you must have an office visit to receive these services.
Preventive care, adult	
Routine screenings, such as: • Vision or hearing • Total Blood Cholesterol – once every three years • Sigmoidoscopy, screening – every five years starting at age 50 • Colorectal Cancer Screening, including –Fecal occult blood test Routine Prostate Specific Antigen (PSA) test– one annually for men age 40 and older 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. $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 and reminder card notifying you of this benefit each year. Take this card with you to your appointment with the Plan eye specialist.	Nothing.
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 and older, one every calendar year 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 mammogram, either screening or diagnostic.	Nothing when this is part of your annual OB/GYN examination or when your Plan provider refers you.
Not covered: • *Physical exams and preparation of specialized reports required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Vision examinations for refractive corrections*	*All charges.*

Preventive care, adult *(Continued)*	**You pay**
Routine Immunizations, including but not limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually, age 50 and over • 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. $10 per office visit if you must have an office visit to receive these services.
Preventive care, children	
• Childhood immunizations recommended by KHP Central 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. $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) • Examinations by your PCP, such as: –Eye exams through age 17 to determine the need for vision correction –Ear exams through age 17 to determine the need for hearing correction –Examinations done on the day of immunizations (up to age 22)	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. $10 per office visit if you must have an office visit to receive these services.
Note: If your child is diabetic she/he may self-refer for one diabetic retinopathy screening to a Plan ophthalmologist or optometrist. You will receive a letter and reminder card notifying you of this benefit each year. Take this card with you to your child's 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: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • 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. • 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. • 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. • 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 range of voluntary family planning services, such as: • Voluntary sterilization (See Surgical procedures Section 5(b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms	$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. Note: Your physician cannot dispense the contraceptive form of Depo provera from the office. You must get it at the pharmacy.	Applicable prescription drug copayment Applicable 90-day prescription drug copayment
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*

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

Allergy care	You Pay
Testing and treatment	$10 per office visit.
Allergy serum Allergy injection	Nothing when we prior authorize your treatment.
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 31. We cover injectable chemotherapy under the medical benefit and oral chemotherapy under the prescription drug benefit. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • 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 the Pharmacy Benefit Manager, Express Scripts (ESI)(these drugs are on the prior authorization list.) Note: – We will only cover GHT when the treatment is prior authorized. You must ask your Plan provider to submit information that establishes that the GHT is medically necessary. Your Plan provider must ask ESI to authorize GHT before you begin treatment; otherwise, GHT serviceswill be covered from the date approval is issued by ESI. If you do not ask or if ESI determines GHT is not medically necessary, GHT or related services and supplies will not be covered. .	Applicable prescription drug copayment.
Physical, Occupational, and Rehabilitative therapies	
Physical therapy, occupational therapy, respiratory therapy, orthoptic therapy, urinary incontinence therapy and cardiac therapy -- • 60 visits per condition per calendar year for the services of each of the following: –Qualified physical therapists; occupational therapists, respiratory therapists; orthoptic therapists; urinary incontinence therapists and cardiac therapists. 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: • *Long-term rehabilitative therapy* • *Exercise programs* • *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 per calendar year 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. $10 per office visit if you must have an office visit to receive these services.
Not covered: • *all other hearing testing* • *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) • 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. $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 and reminder card notifying you of this benefit each year. Take this card with you to your appointment with the Plan eye specialist.	Nothing
Not covered: • *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.* • *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 See orthopedic and prosthetic devices for information on podiatric shoe inserts	$10 per office visit.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Intraocular lenses following cataract removal • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Foot orthotics when an integral part of a leg brace or for severe diabetic foot disease • Braces • 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: • *Orthopedic and corrective shoes* • *Arch supports* • *Heel pads and heel cups* • *Foot orthotics when not an integral part of a leg brace or for severe diabetic foot disease* • *Lumbosacral supports* • *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: • hospital beds • wheelchairs • crutches • canes • walkers • traction equipment • physiotherapy equipment • ostomy supplies • insulin pumps, and diabetic orthotics 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. $10 per office visit for evaluation or fitting. Note: All DME rentals and all DME purchases with a cost of $250 or more per item now require the provider to obtain prior approval from the Plan.
• 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: • *Durable medical equipment requested specifically for travel purposes, recreational or athletic activities or when the intended use is primarily outside the home.* • *Replacement of lost or stolen items within the expected useful life of the originally purchased durable medical equipment.* • *Supplies determined by KHP Central to be not medically necessary.*	*All charges.*

Home health services	You Pay
• 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. • Services include oxygen therapy, intravenous therapy and medications.	Nothing when we prior authorize your treatment.
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges.*
Chiropractic	
• 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 KHP Central. 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; $10 per office visit to your primary care physician or specialist.
Not covered: • *Chronic problems and routine chiropractic maintenance services*	*All charges.*
Alternative treatments	
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupuncture* • *Massage Therapy*	*All charges.*

Educational classes and programs	You Pay
Coverage includes: • 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.
We offer Disease Management Programs that are briefly described below. We continually evaluate various disease states and introduce new programs as appropriate. In addition, we offer Intense Care Management for members with particularly complicated disease states. In these situations, care managers work with you to design a personalized program with your special needs in mind. Information on any of these programs can be obtained by contacting a customer service representative or accessing our website at www.khpc.com. • **Asthma Health Management Program.** Symptoms associated with asthma can affect all aspects of life -- home, work and play. The objective of the Asthma Health Management Program is to improve the quality of life by reducing symptoms through assessment, education, and interventions designed to meet asthmatic Members' individual needs. Our program is designed to empower individuals to take greater responsibility in the management of their disease. • **Diabetes Health Management Program.** Diabetes Health Management Program objectives include preventing the development or progression of diabetes related complications. The program focuses on educating diabetic members about improved self-care, lifestyle modification and personal empowerment. Our program consists of educational mailings, assessment, and interventions based on individualized need. • **Depression Health Management Program.** This program is designed to improve our Members' ability to recognize signs and symptoms of depression and to seek and receive appropriate treatment. The program includes both Member and provider education which focus on early detection, appropriate treatment interventions, reducing the stigma associated with depression, efficient utilization of resources, and other measures to improve Members' psychosocial functioning. • **Nicotine Cessation Health Management Program.** Our Nicotine Cessation Program includes individual assessment, behavioral counseling, telephone support, regular commu nication with the PCP and nicotine replacement therapy, when appropriate.	Nothing. 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 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.
- 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: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Correction of amblyopia and strabismus • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns	Nothing when we prior authorize your treatment.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot Care* • *Any services determined to be not medically necessary by KHP Central*	*All charges.*

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: –the condition produced a major effect on the member's appearance and –the condition can reasonably be expected to be corrected by such surgery • Surgery 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. • All stages of breast reconstruction surgery following a mastectomy, such as: –surgery to produce a symmetrical appearance on the other breast; –treatment of any physical complications, such as lymphedemas; –breast prostheses and surgical bras and replacements (see Prosthetic devices). 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: • *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* • *Surgeries related to sex transformation* • *Any services determined to be not medically necessary by KHP Central*	*All charges.*

Oral and maxillofacial surgery	You pay
Oral and maxillofacial surgical procedures include, but are not limited to: • Surgical correction of congenital defects, such as cleft lip and cleft palate; • 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; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • 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; • Other surgical procedures that do not involve the teeth or their supporting structures; and • Treatment of TMJ, including surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy. Note: If you receive services on an inpatient basis, your doctor must obtain prior authorization from us before we will cover your surgery.	Nothing.
Not covered: • *Oral implants and transplants* • *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	You pay
Include but are not limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Lung: Single –Double • Pancreas • Small bowel • 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. • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. • If not eligible for payment by any other source, the following services of donors to a KHP Central 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: • *Donor screening tests and donor search expenses* • *Transplants not listed as covered* • *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.* • *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 – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • 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 PRIOR AUTHORIZATION 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 • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • 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: • *Custodial care* • *Non-covered facilities, such as nursing homes and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care unless medically necessary* • *Take-home items* • *Whole blood, blood plasma or blood components*	*All charges.*

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 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: • Room, 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.	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 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.

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.

Transportation and related emergency services provided by a licensed ambulance service are also covered benefits, if the condition is as described above. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In a true Emergency, your first concern is to obtain necessary medical treatment. If the circumstances prevent you from contacting your PCP, seek Emergency medical care from the nearest appropriate facility. A Referral from your PCP is not required in a true Emergency.

If KHP Central determines that the services constitute an Emergency Service as defined above, charges incurred will be covered by KHP Central. Otherwise, the services will NOT be covered by KHP Central.

NOTE: Please contact your PCP within forty-eight (48) hours after the incident so that necessary follow-up care can be arranged. 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 Customer Service Department at 1-800-622-2843 (TDD 1-800-669-7075).

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 should 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 should contact your PCP as soon as possible, but within 48 hours unless it was not reasonably possible to do so.

What to do in case of an urgent situation:

Urgent care is care for an unexpected illness or injury which does not require emergency services but which may need prompt medical attention. Some examples of urgent situations are: cold, sore throat, cough, fever, vomiting, sprain, strain, cramps, diarrhea, bumps, bruises, small lacerations, minor burns, earache, rashes, swollen glands, and possible broken bones.

Urgent care within our service area: In the event of an urgent situation, first call your PCP. He or she will give you instructions and refer medical care appropriate to the situation. In most circumstances, you will NOT be directed to an emergency room of a hospital for urgent Care. In the event that you are unable to obtain a PCP referral for medically necessary care in advance of receipt of the urgent care services, you should notify the PCP within 48 hours of the receipt of care or the next business day.

Urgent care outside our service area: In the event that you require urgent care outside of the service area, you should contact BlueCard at 1-800-810-2583 or via the Internet at www.bcbs.com to determine if there is a BlueCard participating provider in the area. If there is such a provider, BlueCard will provide a list of area providers who can deliver the care you require. You will then be responsible for choosing a Provider and arranging an appointment. If there is not a participating provider in the area, you will need to contact your PCP. In either case, you should contact your Primary Care Physician within forty-eight (48) hours of receiving the care to inform them of the visit. You must contact your PCP prior to receiving care under BlueCard *Follow-Up* care. Urgent Care received outside the Service Area will be considered covered only if, in the determination of KHP Central:

- You could not have anticipated the need for such services prior to leaving the Service Area; and
- You contact BlueCard prior to service; or
- Your Primary Care Physician coordinates the service.

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	You pay
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	Same as for Emergency within our service area.
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*	*All charges when we do not prior authorize your treatment.*
Ambulance	
Professional ambulance services when medically appropriate. These include, but are not limited to: • Air ambulance • Basic life support • Advanced life support • Invalid coach service 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

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

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 and are payable only when we determine they are medically necessary.
- 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. 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 • 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. $10 per office visit if you must have an office visit to receive these services.
• Services provided by a hospital or other facility • 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. *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.*

Your mental health and substance abuse treatment is provided through a subcontract with PacifiCare Behavioral Health, a behavioral health managed care company. PacifiCare 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.

You must contact PacifiCare Behavioral Health (PBH) at 1-800-216-9748 (TDD number at 1-888-877-5378) to identify PBH network providers and determine which provider best meets your needs. If outpatient non-emergency services are not received from a PacifiCare Behavioral Health network provider, these will NOT be covered. If you are faced with a crisis, contact PBH at 1-800-216-9748 (TDD number 1-888-877-5378). PacifiCare Behavioral Health Care Management Team and network providers are available 24 hours a day, 7 days a week, to offer assistance and coordinate care. PacifiCare also offers translator services to its non-English speaking members. To access this service, simply contact PacifiCare at 1-800-216-9748. The Behavioral Health Provider you choose 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 PacifiCare Behavioral Health. PacifiCare 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 your PCP or PacifiCare 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

IMPORTANT

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 44.
- 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.

IMPORTANT

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

- **Who can write your prescription?** A plan provider or a provider 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 service pharmacy. At a participating pharmacy, simply show your KHP Central ID card when you present your prescription and you pay only the amount of the copayment or coinsurance specified by your KHP Central 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, KHP Central's Pharmacy Benefit Manager, for reimbursement of KHP Central's cost, less the amount of your copayment or coinsurance. All Member Direct Submission Forms must be submitted within ninety (90) days of the pharmacy receipt date. A Member Direct Submission Form can be obtained by calling KHP Central's Customer Service Department at 1-800-622-2843 (TDD 1-800-669-7075), or by e-mailing us at CustomerService@khpc.com.

  If you go to a non-participating pharmacy, you are responsible for paying the full cost of 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 KHP Central at the following address: KHP Central Customer Service Department, P.O. Box 898880, Camp Hill, PA 17089-8880. If after reviewing your request, KHP 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 ninety (90) days of the pharmacy receipt date to be considered for reimbursement.

  Prescription mail service is provided through the Express Scripts Mail Service Pharmacy. Using the mail service pharmacy for maintenance drugs (drugs used on an ongoing basis for chronic conditions) helps to save you time and money by having prescription drugs delivered directly to your home. An Express Scripts Mail Service Pharmacy packet can be obtained by calling KHP Central's Customer Service Department at 1-800-622-2843. Follow the directions that are included in the packet to order your prescriptions. Or, you can order your prescriptions online by visiting KHP Central's website at www.khpc.com. This will provide you with a link to Express Scripts' online pharmacy.

  You may return drugs to Express Scripts that were filled at the Express Scripts Mail Service Pharmacy in the following instances:
  - When the prescription is filled incorrectly (not as written by the prescribing provider).
  - When the prescription is damaged during shipment.
  - When the prescription has been changed to another drug without the prescribing provider's approval.

  In the event that any of the situations outlined above occurs, your account with Express Scripts will be credited the amount of your copayment or coinsurance. Drugs that are returned to Express Scripts for any reason other than those listed above will not result in any type of account credit. This includes reasons such as discontinuation of treatment or cost of the drug.

- **We use a formulary.** KHP Central uses a drug formulary to help manage your prescription drug benefit. The KHP Central drug formulary is a list of medications intended to guide your provider's prescription drug prescribing decisions. The KHP Central Pharmacy and Therapeutics Committee (P&T Committee) developed the drug formulary. The P&T Committee meets quarterly to review new and existing prescription drugs on the basis of safety, effectiveness, and cost in order to ensure that the drug formulary remains responsive to the needs of members and providers. Therefore, the drug formulary is subject to change throughout the year. Updates to the drug formulary will be reported quarterly in the KHP Central member newsletter.

  Under the KHP Central drug formulary, drugs are classified into one of three tiers – generic drugs (1st tier), preferred brand drugs (2nd tier), or non-preferred brand drugs (3rd tier). Copayments are assigned for each tier and increase incrementally from the first through the last tier. If you have questions regarding the tier placement of a prescription drug, or if you would like to request a copy of KHP Central's drug formulary, call KHP Central's Customer Service Department at 1-800-622-2843 or visit KHP Central's website at www.khpc.com

- **These are the dispensing limitations.** KHP Central encourages the use of Generic Drugs through the generic program. When a generic drug is dispensed, you are responsible for paying only the applicable generic copayment or coinsurance. When a brand drug is dispensed that has a generic equivalent, you are responsible for paying the applicable brand copayment or coinsurance plus the difference in price between the brand drug and its generic equivalent, up to the original cost of the brand drug. KHP Central has a Brand Drug Consideration Process whereby a provider may request that coverage for a preferred or non-preferred brand drug be granted when medical necessity is substantiated in writing. When granted, you are responsible for paying only the applicable brand drug copayment or coinsurance. Note: When a brand drug is dispensed that has no generic equivalent, you are responsible for paying only the applicable brand drug copayment or coinsurance.

  Up to a ninety (90) day supply of drugs can be obtained at a participating pharmacy by paying your applicable copayment or coinsurance for each thirty (30) day supply or unit-of-use. You can request that your prescription be refilled after approximately seventy-five percent (75%) of the quantity has been used.

  When you use the mail service pharmacy, you can purchase up to a ninety (90) day supply of drugs at one time by paying your applicable mail service copayment or coinsurance for each prescription. You will receive instructions with each order explaining how to reorder your drugs. You can request that your mail service prescription be refilled after approximately sixty percent (60%) of the quantity has been used.

- **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 - is 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. 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. 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 their Pharmacy Benefit Manager, Express Scripts, to review requests for certain prescription drugs and compare them with clinical guidelines for appropriateness. Delays may occur in receiving these drugs to allow for clinical review of provider submitted information.

  Another form of prior authorization that KHP Central uses is step-therapy. Step-therapy applies to select classes of prescription drugs, whereby a second-line drug is only authorized if the therapy outcome is not satisfactory to a first-line, or prerequisite drug. If a first-line drug has not been tried, the second-line drug will not be covered. If the prescribing provider believes that it is medically necessary for a second-line drug to be used without trial of a first-line drug, the provider can request consideration through Express Scripts. If a member is currently taking a second-line drug, then continuance on that drug is permitted without trial of a first-line drug.

  Questions regarding which prescription drugs require prior authorization may be directed to the Plan's Customer Service Department at 1-800-622-2843 (TDD 1-800-669-7075). Additionally a list 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 drug requires prior authorization, your doctor may either call Express Scripts at 1-800-889-0376 or fax a completed Prescription Prior Authorization Form, along with any supporting documentation, to Express Scripts at 1-800-357-9577. 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 drug that requires prior authorization and try to obtain the drug at the pharmacy without having obtained prior authorization, your doctor will receive a phone call from the pharmacist and/or Express Scripts to obtain the information. Therefore, it will be more convenient for you and your provider to provide this information in advance. If necessary, the Express Scripts reviewers will contact your provider 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 drug 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 provider and to us within two (2) working days of making the decision. You and/or the prescribing provider, **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 provider and obtained from a Plan pharmacy or through our mail service pharmacy: • Drugs on the Keystone Health Plan Central drug formulary • Drugs for which a prescription is required by State or Federal law of the United States require a provider's prescription for their purchase, except those listed as *Not covered*. • Insulin • Diabetic supplies including alcohol wipes/pads, syringes, needles, glucose test strips, lancets, and one (1) blood glucose monitor in a calendar year • Compounded preparations containing at least one prescription drug • Contraceptive drugs and devices • Disposable needles and syringes for the administration of covered medications • Oral chemotherapy	At a participating pharmacy: ▪ A $10 (generic)/ $25 (preferred brand)/ $40 (non-preferred brand) copayment for up to a **30-day** supply per prescription unit or refill; ▪ A $20 (generic)/ $50 (preferred brand)/ $80 (non-preferred brand) copayment for up to a **60-day** supply per prescription unit or refill; ▪ A $30 (generic)/ $75 (preferred brand)/ $120 (non-preferred brand) copayment for up to a **90-day** supply per prescription unit or refill. From the Express Scripts mail service pharmacy: ▪ A $20 (generic)/ $50 (preferred brand)/ $80 (non-preferred brand) copayment for up to a **90-day** supply per prescription unit or refill. Note: ▪ If a preferred brand drug is dispensed that has a generic equivalent, you will be responsible for paying the preferred brand drug copayment plus the difference in price between the preferred brand drug and the generic equivalent, up to the original cost of the preferred brand drug. ▪ If a non-preferred brand drug is dispensed that has a generic equivalent, you will be responsible for paying the non-preferred brand drug copayment plus the difference in price between the non-preferred brand drug and the generic equivalent, up to the original cost of the non-preferred brand drug.

Covered medications and supplies (continued)	You Pay
• Drugs for sexual dysfunction are subject to dose or quantity limitations. Call the Plan for specific limitations. • Oral drugs used to treat infertility can be purchased from a participating pharmacy or from the mail service pharmacy. Quantities are limited to a maximum of a 90-day supply. NOTE: Oral drugs used to treat infertility are covered as long as infertility is not due, in part or in its entirety, to either party (whether a KHP Central member or not) having undergone a voluntary sterilization procedure and/or reversal of the voluntary sterilization procedure that was not successful.	50% coinsurance.
Not covered: • *Drugs that do not legally require a written prescription from a health care professional licensed to prescribe drugs (other than insulin)* • *Drugs that have an over-the-counter (non-prescription) equivalent* • *Nutritional or dietary supplements including vitamins and nutritional supplements available without a prescription* • *Medical supplies such as dressings and antiseptics, except diabetic supplies as indicated on the benefit list* • *Drugs and supplies for cosmetic purposes* • *Drugs used in conjunction with non-covered medical services* • *Drugs to enhance physical or athletic performance* • *Drugs to promote weight loss, except for treatment of morbid obesity** • *Drugs which are investigational or experimental in nature, as determined by Keystone Health Plan Central in accordance with this Program* • *Immunization agents, biological sera, blood or blood product* • *Prescription drugs received in and/or billed by a home health care agency, hospital, skilled nursing facility, assisted living facility or similar institution which may be provided under the medical benefit* • *Venoms, allergy serums and desensitization serums* • *Smoking Cessation drugs and products ** • *Drugs prescribed and administered in the provider's office* • *Replacement prescription resulting from loss, theft, or damage* • *Except in emergency situations, drugs purchased from a non-participating pharmacy* • *Request for reimbursement filed more than ninety (90) days after the pharmacy receipt date* **Note: When smoking cessation drugs and products, and drugs to promote weight loss (except for treatment of morbid obesity, which is a covered benefit) are prescribed by a KHP Central participating provider or a provider to whom you have been referred, they may be obtained at a participating pharmacy or mail service pharmacy at a coinsurance equal to 100% of KHP Central's cost of the prescription drug. Otherwise, these drugs are considered not covered under your prescription drug benefit.*	All Charges

Section 5 (g). Special Features

Feature	Description
BlueCard Urgent Care – Out of Area Services	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 PCP must coordinate your follow up care or it will not be covered. **In the event of an Emergency:** The member seeks immediate assistance at the nearest medical facility. The member should contact his or her Primary Care Physician within 48 hours after the incident so that necessary follow-up care can be arranged.
Away From Home Care-Guest Membership	If you or a dependent 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 Away From Home Guest Membership program as described below. Guest memberships give you and your dependents coverage (similar to that provided by KHP Central) 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 KHP Central. 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. To find out if you or your Dependents are eligible for the Guest Membership Program, please call KHP Central's Customer Service Department at **1-800-622-2843** toll-free (TDD number at **1-800-669-7075** for the hearing impaired). 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 KHP Central'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 1,100 health related topics.
www.khpc.com	You can search our website 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

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 doctors must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when certain nondental physical impairments exist which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- 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

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 fro m 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 catastrophic protection out-of-pocket maximums.

Wellness Discount Directory

Keystone Health Plan Central (KHP Central) believes that providing access to health care is important – even when you're not sick. To help encourage you to improve and maintain your overall health, we've arranged for you to receive discounts for health and fitness services at certain facilities within the KHP Central service area. The Wellness Discount Directory lists all of the facilities, organizations, and practitioners that offer discounts. This information is available from KHP Central in hard copy or on our website. Participants in the program are listed by county and may include: Acupuncture, Chiropractic, Massage Therapy, Fitness Centers, and Nutrition Centers. You must show your KHP Central identification card to obtain the applicable discounts.

These discounts are not included in the KHP Central health benefits plan and are provided strictly as a convenience and courtesy to KHP Central members.

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 13-14.

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.
- Services, drugs, or supplies you receive without charge while in active military service.

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 KHP Central 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 services you receive outside of the Plan's service area – 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 copayment or coinsurance for prescription drugs in an emergency situation. If you must file a claim for prescription drugs, contact us at 1-800-622-2843 and we will help you. You must request any reimbursement within 90 days of the pharmacy receipt date.

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: (a) Write to us within 6 months from the date of our decision; and (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 (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	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. 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. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.

The Disputed Claims Process (Continued)

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 more than one claim, 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.

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 1-800-622-2843 (TDD number 1-800-669-7075) 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 may 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 or a covered family member have coverage 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 (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare

Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. 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.

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 then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at 1-800-622-2843.

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

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		✓

· **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from 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 cost-sharing 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 and CHAMPVA

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

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

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.

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See 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. Custodial care that lasts 90 days or more is sometimes know as Long term care.

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 FEHB.

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 KHP Central 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 your FEHB coverage. These materials tell you:

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

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

Types of coverage available for you and your family

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive 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.

Children's Equity Act

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

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

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

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

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.

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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

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

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

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

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

· **Converting to individual coverage**

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

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

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

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

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans. For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (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 Still Available

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

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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- 2003

- **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: • Diagnostic and treatment services provided in the office	Office visit copayment: $10 primary care; $10 specialist	17
Services provided by a hospital: • Inpatient..... • Outpatient.....	 Nothing Nothing	 34 35
Emergency benefits: • In-area ..... • Out-of-area	 $25 per emergency room visit $25 per emergency room visit	38 39
Mental health and substance abuse treatment	Regular cost sharing	40
Prescription drugs..... For up to a 90-day supply per prescription unit or refill for generic drugs or name brand drugs	At a participating retail pharmacy: ▪ $10/$25/$40 copayment for up to a **30-day** supply ▪ $20/$50/$80 copayment for up to a **60-day** supply ▪ $30/$75/$120 copayment for up to a **90-day** supply From the mail service pharmacy: ▪ $20/$50/$80 copayment for up to a **90-day** supply Note: When a generic drug is dispensed, you are responsible for paying only the applicable generic copayment. When a brand drug is dispensed that has a generic equivalent, you are responsible for paying the applicable brand copayment plus the difference in price between the brand drug and its generic equivalent, up to the original cost of the brand drug.	42

Dental Care ..... 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	49
Vision Care	No benefit.	24
Special features: BlueCard Urgent Care – Out of Area Services; Away From Home Care-Guest Membership; *Keeping Well;* HealthLink; and www.khpc.com.		47
Protection against catastrophic costs (your out-of-pocket maximum)	We do not have an out-of-pocket maximum	15

2003 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 a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		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	$109.30	$46.91	$236.82	$101.64	$129.03	$27.18
Self and Family	S42	$249.62	$128.74	$540.84	$278.94	$294.70	$83.66