



Keystone Health Plan Central

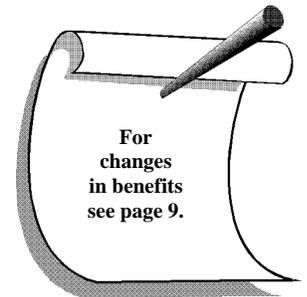
2005

<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 8 for requirements.



This Plan has an Excellent accreditation from the NCQA. See the 2005 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**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>



OFFICE OF THE DIRECTOR

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

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.shtml, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

Kay Coles James

Director



Notice of the United States Office of Personnel Management's Privacy Practices

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 United States 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 health care 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 202-606-0745 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
Unites States 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 United States 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 are 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 United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Keystone Health Plan Central administrative offices is:

Keystone Health Plan Central
2500 Elmerton Avenue
Harrisburg, PA 17177-9799

This walk-in location is available to KHP Central Members daily, Monday through Friday from 8:00 a.m. to 4:30 p.m.

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, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 9. 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 United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

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

Stop Health Care Fraud!

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

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

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

- 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:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

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

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

3. Get the results of any test or procedure.

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery?
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

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

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, 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 pay only the copayments, coinsurance, and deductibles 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 Improvement Program.

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

Keystone Health Plan Central
P.O. Box 779855
Harrisburg, PA 17177-9855

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 779855, Harrisburg, PA 17177-9855 or fax us at 1-866-405-6382. You may also 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 and urgent 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 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 KHP Central ID card and pay the applicable copayment while you are at your appointment.
- You must contact your PCP 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. Please note that not all geographic areas within the United States participate in the Guest Membership Program.

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 2005

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

- In Section 9, we revised the Medicare Primary Payer Chart and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program.

Changes to this Plan

- Your share of the non-Postal premium will increase by 46% for Self Only or 41% for Self and Family.
- You will now have a \$200 inpatient copayment. You will be responsible for paying \$200 for each inpatient admission. Medically necessary inpatient stays in a hospital (including inpatient admissions resulting from a visit to an emergency room), skilled nursing facility, rehabilitation hospital, or chemical dependency treatment facility are subject to the \$200 copayment per admission. If you are moved to another hospital, skilled nursing facility, rehabilitation hospital or chemical dependency treatment facility or are readmitted to the same hospital, skilled nursing facility, rehabilitation hospital, or chemical dependency treatment facility within ten (10) days of discharge, you will not be charged the \$200 inpatient copayment. However, you will still be responsible for paying the \$200 copayment for the initial inpatient admission.

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) or write to us at Keystone Health Plan Central, P.O. Box 779855, Harrisburg, PA 17177-9855, fax us at 1-866-405-6382 or email 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, deductibles, and/or coinsurance, and you will not have to file claims, unless you receive emergency services from a provider who doesn’t contract with us.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website. You can view our website at www.khpc.com or call our 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 that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website. You can view our website at www.khpc.com or call our 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**

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 must provide or refer all follow-up care. Do not go to the specialist for return visits unless your PCP gives you a 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 referral form. In some cases, you will be required to obtain an additional referral 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.

Standing Referral. If you are afflicted with a life-threatening, degenerative or disabling disease or condition, a standing Referral may be given to a specialist with the appropriate clinical experience in treating the disease or 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 must be obtained from your PCP. The referral 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 may 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 Referral. 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, which is also referred to as behavioral health services, is provided through a subcontract with PacifiCare Behavioral Health, Inc. (PBH), 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.

Prior to accessing non-emergency services, you must contact PacifiCare Behavioral Health at 1-800-216-9748 (TDD number at 1-888-877-5378). Through a brief telephone conversation, PBH personnel will help identify your individual needs. They will ask questions to better understand your cultural (linguistic, age, gender), clinical (type of concern such as depression, chemical dependency), and geographic (where you live or work) needs. Using this information, PBH will provide you with the names of providers who can best meet your needs. The PBH provider you choose will be responsible for providing and/or coordinating your mental health/chemical dependency treatment. For outpatient non-emergency services to be covered, the services must be received from a PBH network provider and must have a prior notification to PBH. A listing of all participating mental health and chemical dependency providers is included in the KHP Central Participating Physicians, Pharmacies, and Hospitals Directory and its updates, and on KHP Central's website at www.khpc.com.

If you are faced with a crisis, contact PBH at 1-800-216-9748 (TDD number at 1-888-877-5378). PBH's Care Managers and network providers are available twenty-four (24) hours a day, seven (7) days a week, to offer assistance and coordinate care.

PBH also offers translator services to its non-English speaking members. To access this service, simply call PBH.

Inpatient Services - Mental Health or Chemical Dependency. If a need for inpatient care is identified, the inpatient stay must be prior authorized by PacifiCare Behavioral Health, Inc.

Emergency services do not have to be prior authorized, but you or your family should contact PacifiCare Behavioral Health after receiving these services but before receiving follow-up 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 (PCP) 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, except for true emergencies.

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

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process "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
- Botulinum toxin injections
- Cancer clinical trials

- Cancer therapies (inpatient only)
- Durable Medical Equipment (DME) - all eligible rental items, and/or all eligible purchased items, including repairs and adjustments, 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
 - Ocular photodynamic (Visudyne) therapy
 - Oncologic photodynamic (Porfimer) therapy
 - Rabies Vaccine & Immunoglobulin
 - The following commonly self-administered drugs when given by a health care professional (administration only beyond the first 2 injections):
 - Epogen/Procrit/Aranesp (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
- Enhanced External Counterpulsation (ECP)
- 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
- Hyperbaric oxygen (HBO) therapy
- 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 PCP
- 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 when performed outside an office setting:
 - Arthrocentesis
 - Aspiration of a joint
 - Colposcopy
 - Electrodesiccation condylomata - *complex*
 - Excision of a chalazion
 - Excision of a nail, partial or complete
 - Excision of all types of benign lesions (2.0 cm or less)
 - Enucleation or excision of external thrombotic hemorrhoid(s)
 - 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
 - Repair of lacerations, including suturing (2.5 cm or less)
 - 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 (including evaluations and re-evaluations more frequently than every 30 days), occupational (including evaluations and re-evaluations more frequently than every 30 days), speech, cardiac, respiratory, vision, and urinary incontinence
- Scanning Computerized Ophthalmic Diagnostic Imaging
- Surgeries - all outpatient facility based surgeries, including hospitals and ambulatory surgical centers (excluding endoscopic procedures except those listed in herein)
- Transcatheter Arterial Embolization (TACE)
- Transplant evaluations
- Wireless Capsule Endoscopy (WCE)

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.

Questions regarding which services require prior authorization may be directed to KHP Central's Customer Service Department at 1-800-622-2843. Additionally a list of services requiring prior authorization is available on KHP Central's website at www.khpc.com

Section 4. Your costs for covered services

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

Copayments

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

Examples: When you see your primary care physician (PCP) you pay a copayment of \$15 per office visit and when you go in the hospital, you pay a copayment of \$200 per admission.

If you use an emergency room for emergency services you will pay \$50 per visit. This copayment is waived if you are admitted to the hospital at that time. However, if you are admitted you will pay a \$200 inpatient copayment. 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 \$15 per visit.

Deductible

We do not have a deductible.

Coinsurance

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

Example: In our Plan, you pay 50% of our allowance for services and medications to treat infertility, and medications for treatment of erectile 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 9 for how our benefits changed this year and page 74 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), via fax at 1-866-405-6382 or at our website at www.khpc.com, or email us at CustomerService@khpc.com.

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

Here are some important things you should keep in mind about these benefits:

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- 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.

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • Second surgical opinion 	\$15 per PCP office visit \$20 per specialist office visit \$25 per office visit if you see your PCP for services during hours other than those regularly scheduled for appointment
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility 	\$50 per visit Nothing for the professional services of physicians. However, you have a \$200 inpatient copayment per admission. Nothing for the professional services of physicians. However, you have a \$200 inpatient copayment per admission.
At home	\$15 per PCP visit \$20 per specialist visit \$25 per visit if you see your PCP for services during hours other than those regularly scheduled for appointments.

Diagnostic and treatment services – continued on next page

Lab, X-ray and other diagnostic tests	You pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	<p>Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.</p> <p>\$15 per PCP office visit or \$20 per Specialist office visit if you must have an office visit to receive these services.</p>
Preventive care, adult	
<p>Routine screenings, such as:</p> <p>Total Blood Cholesterol</p> <p>Colorectal Cancer Screening, including:</p> <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – Double contrast barium enema – every five years starting at age 50 – Colonoscopy screening – every ten years starting at age 50 	<p>Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.</p> <p>\$15 per PCP office visit or \$20 per Specialist office visit if you must have an office visit to receive these services.</p>
<p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p>	<p>Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.</p> <p>\$15 per PCP office visit or \$20 per Specialist office visit if you must have an office visit to receive these services.</p>

Preventive care, adult – continued on next page

Preventive care, adult <i>(continued)</i>	You pay
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. \$15 per PCP office visit or \$20 per Specialist office visit if you must have an office visit to receive these services.
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 and older, one every calendar year Members may self-refer to a participating provider for a mammogram, either screening or diagnostic.	Nothing when this is part of your annual OB/GYN examination or when you obtain services from a participating provider. \$15 per PCP office visit or \$20 per Specialist office visit if you must have an office visit to receive these services.
Routine immunizations, including but not limited to: <ul style="list-style-type: none"> • 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 older 	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. \$15 per PCP office visit or \$20 per Specialist 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 be mailed a notice of this benefit each year. Take the notice with you to your appointment with the Plan eye specialist.	Nothing.
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical exams and preparation of specialized reports required for obtaining or continuing employment or insurance, attending schools or camp, or travel, except when such service coincides with a covered health maintenance office visit.</i> • <i>Vision examinations for refractive corrections</i> 	<i>All charges.</i>

Preventive care, children	You pay
<ul style="list-style-type: none"> Childhood immunizations recommended by KHP Central Health Maintenance guidelines 	<p>Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.</p> <p>\$15 per PCP office visit or \$20 per Specialist office visit if you must have an office visit to receive these services.</p>
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations by your PCP, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) 	<p>Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.</p> <p>\$15 per PCP office visit or \$20 per Specialist office visit if you must have an office visit to receive these services.</p>
<p>NOTE: If your child is diabetic she/he may self-refer for one diabetic retinopathy screening to a Plan ophthalmologist or optometrist. You will be mailed a notice of this benefit each year. Take the notice with you to your child's appointment with the Plan eye specialist.</p>	<p>Nothing.</p>
<p><i>Not covered: Vision examinations for refractive corrections</i></p>	<p><i>All charges.</i></p>
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care <p>NOTE: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> 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). 	<p>Nothing when we prior authorize your treatment.</p>
<p><i>Not covered:</i></p> <p><i>Routine sonograms to determine fetal age, size or sex.</i></p> <p><i>Neonatal circumcisions.</i></p>	<p><i>All charges.</i></p>

Family planning	You pay
<p>A range of voluntary family planning services, such as:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p> <p>Note: Your physician cannot dispense the contraceptive form of Depo provera from the office. You must obtain it under the prescription drug program.</p>	<p>\$15 per PCP office visit or \$20 per Specialist office visit if you must have an office visit to receive these services</p> <p>Applicable prescription drug copayment</p> <p>Applicable 90-day prescription drug copayment</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling.</i> 	<p><i>All charges.</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	<p>50% of the cost of the treatment when authorized by KHP Central</p> <p>50% of the cost of the medications. You can receive up to a 90-day supply at one time.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Services for dependent children, regardless of age</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<p><i>All charges.</i></p>

Allergy care	You pay
Testing and treatment	\$15 per PCP office visit or \$20 per Specialist office visit.
Allergy serum	Nothing when administered or referred by your PCP.
Allergy injections	Nothing when we prior authorize your treatment.
<p><i>Not covered:</i></p> <p><i>The following immunotherapy and testing methods are not covered:</i></p> <p><i>Immunotherapy –</i></p> <ul style="list-style-type: none"> • <i>Provocative and neutralization therapy for food allergies</i> • <i>Sublingual</i> • <i>Urine autoinjections</i> • <i>Repository emulsion therapy</i> • <i>Serial dilution endpoint titration therapy</i> <p><i>Testing –</i></p> <ul style="list-style-type: none"> • <i>Cytotoxic food testing</i> • <i>Leukocyte histamine release</i> • <i>Provocative testing for food or food additive allergies</i> • <i>Sublingual (antigens prepared for sublingual administration)</i> • <i>Serial dilution endpoint titration (SDET)/Skin endpoint titration (SET)</i> • <i>Nasal challenge testing</i> • <i>Conjunctival challenge testing (ophthalmic mucous membrane testing)</i> • <i>Rebuck skin window testing</i> • <i>Elisa/Act qualitative antibody testing and IgG ELISA, indirect method</i> 	<p><i>All charges.</i></p>

Treatment therapies	You pay
<ul style="list-style-type: none"> Chemotherapy and radiation therapy <p>NOTE: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 36. We cover injectable chemotherapy under the medical benefit and oral chemotherapy under the prescription drug benefit.</p> <ul style="list-style-type: none"> Respiratory and inhalation therapy Dialysis – hemodialysis and peritoneal dialysis Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy 	<p>Nothing when we prior authorize your treatment.</p>
<ul style="list-style-type: none"> 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.) <p>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 services will 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.</p>	<p>Applicable prescription drug copayment.</p>
Physical and occupational therapies	
<p>Physical therapy, occupational therapy, respiratory therapy, orthoptic therapy, urinary incontinence therapy and cardiac therapy --</p> <ul style="list-style-type: none"> 60 visits per condition per calendar year for the services of each of the following: <ul style="list-style-type: none"> –Qualified physical therapists; occupational therapists, respiratory therapists; orthoptic therapists; urinary incontinence therapists and cardiac therapists. <p>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.</p>	<p>Nothing when we prior authorize your treatment and you are referred by your Plan provider.</p> <p>\$20 per evaluation and re-evaluation.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Long-term rehabilitative therapy</i> <i>Exercise programs</i> <i>Rehabilitative therapy services, including spinal manipulation therapy, for chronic problems or routine maintenance for chronic conditions</i> 	<p><i>All charges.</i></p>
Speech therapy	
<ul style="list-style-type: none"> 60 visits per condition per calendar year for the services of qualified speech therapists 	<p>Nothing when we prior authorize your treatment and you are referred by your Plan provider.</p> <p>\$20 per evaluation and re-evaluation.</p>

Hearing services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> Hearing testing for children through age 17 (see <i>Preventive care, children</i>) Hearing screening for diagnostic purposes when related to a medical diagnosis when provided or referred by your Plan physician 	<p>Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.</p> <p>\$15 per PCP office visit or \$20 per Specialist office visit if you must have an office visit to receive these services.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> All other hearing testing Hearing aids, testing and examinations for them 	<p>All charges.</p>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> 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 physician 	<p>Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.</p> <p>\$15 per PCP office visit or \$20 per Specialist office visit if you must have an office visit to receive these services.</p>
<p>NOTE: If you are diabetic you may self-refer for one diabetic retinopathy screening to a Plan ophthalmologist or optometrist. You will be mailed a notice of this benefit each year. Take the notice with you to your appointment with the Plan eye specialist.</p>	<p>Nothing.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eyeglasses or contact lenses and after age 17, examinations for them 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 	<p>All charges.</p>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$15 per PCP office visit or \$20 per Specialist office visit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<p>All charges.</p>

Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • 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. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Intraocular lenses following cataract removal • Foot orthotics when an integral part of a leg brace or for severe diabetic foot disease • Braces 	<p>Nothing when prior authorized by us and purchased from an approved supplier.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics when not an integral part of a leg brace or necessary for the management of severe diabetic foot disease or its complications</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Cost of penile implanted device</i> 	<p><i>All charges.</i></p>

Durable medical equipment (DME)	You pay
<p>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:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; • Crutches; • Canes; • Walkers; • Traction equipment; • Physiotherapy equipment; • Ostomy supplies; • Insulin pumps, and diabetic orthotics <p>NOTE: Diabetic-related supplies and blood glucose monitors are covered under Prescription drug benefits.</p>	<p>Nothing when prior authorized by us and purchased from an approved supplier.</p> <p>\$15 per PCP office visit or \$20 per Specialist office visit for evaluation or fitting.</p> <p>Note: All DME rentals and all DME purchases, including repairs and adjustments, with a cost of \$250 or more per item require the provider to obtain prior approval from the Plan.</p>
<ul style="list-style-type: none"> • Hair prostheses limited to 2 per member per calendar year with a maximum Plan payment of \$400 per prosthesis 	<p>Any remaining amount above the Plan maximum of \$400 per prosthesis, with a limit of 2 per member per calendar year.</p>
<ul style="list-style-type: none"> • Oral appliances for sleep apnea are limited to a maximum Plan payment of \$340 per appliance 	<p>Any remaining amount above the Plan maximum of \$340 per appliance.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Durable medical equipment requested specifically for travel purposes, recreational or athletic activities or when the intended use is primarily outside the home.</i> • <i>Replacement of lost or stolen items within the expected useful life of the originally purchased durable medical equipment.</i> • <i>Supplies determined by KHP Central to be not medically necessary.</i> 	<p><i>All charges.</i></p>
Home health services	
<ul style="list-style-type: none"> • 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. 	<p>Nothing when we prior authorize your treatment.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>Homemaker services and other non-medical home health care services.</i> 	<p><i>All charges.</i></p>

Chiropractic	You pay
<ul style="list-style-type: none"> 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. 	\$15 per PCP office visit or \$20 per Specialist office visit.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Chronic problems and routine chiropractic maintenance services</i> 	<i>All charges.</i>
Alternative treatments	
<p><i>No benefit</i></p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Naturopathic services</i> <i>Hypnotherapy</i> <i>Biofeedback</i> <i>Acupuncture</i> <i>Massage Therapy</i> 	<i>All charges.</i>

Educational classes and programs	You pay
<p>Coverage includes:</p> <ul style="list-style-type: none"> • Childbirth Preparation Classes: You can receive up to a \$75 reimbursement for Childbirth Preparation Classes. After completing the course, forward your certificate of completion and your receipt of payment to us for reimbursement. 	<p>Any balance over our \$75 reimbursement.</p>
<ul style="list-style-type: none"> • 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. If you are interested in a diabetic education class, please discuss this with your PCP. 	<p>Nothing when we prior authorize your treatment.</p>

Educational classes and programs	You pay
<p>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 those situations, care managers work with you to design a personalized program with your special needs in mind.</p> <p>Information on any of these programs can be obtained by contacting a customer service representative or accessing our website at www.khpc.com.</p> <ul style="list-style-type: none"> <p>Asthma Health Management Program. This program is designed to help Members learn how they can control their symptoms. 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.</p> <p>Diabetes Health Management Program. Diabetes Health Management Program objectives include preventing the development or progression of diabetes related complications. This program is designed to help members avoid developing other health problems such as heart disease, eye disorders, and kidney disease. The program teaches members how to eat better and monitor their sugar levels.</p> <p>Depression Health Management Program. This program is designed to promote the early detection and treatment of depression through educational interventions. Members and providers receive important information related to the signs and symptoms of depression, appropriate treatment options, and the impact that depression has on other areas of an individual's life and health. The program also focuses on reducing the social stigma of depression, promoting the efficient utilization of resources, and improving overall health status.</p> <p>Nicotine Cessation Health Management Program. Our Nicotine Cessation Program is designed to help members stop smoking and using other nicotine products (such as snuff, chew, etc.). We try to understand why a member smokes (or uses other nicotine products) and teach them how to stop.</p> 	<p>Nothing.</p>

Educational classes and programs	You Pay
<ul style="list-style-type: none"> • Maternity Management Program. The Maternity Management Program is designed to help expectant mothers learn how to make healthy choices that are good for her and her unborn child. The anticipated outcome is a healthy mother and a healthy full-term infant. The program addresses normal pregnancy issues, as well as the special needs for a high-risk pregnancy. • Heart Failure Health Management Program. This program is designed to help teach members how to manage their disease. Heart failure can cause symptoms of fatigue, shortness of breath, and fluid weight gain. The program teaches members the importance of eating healthy, exercise, weight control, and taking prescribed medications. Learning how to self-manage heart failure can decrease the symptoms mentioned above and increase quality of life. • Chronic Obstructive Pulmonary Disease (COPD) Health Management Program. COPD is a term used for two closely related disease of the respiratory system: <i>chronic bronchitis and emphysema</i>. This program focuses on nutrition, breathing techniques, activity level and conservation, oxygen, environmental issues and medications. By understanding what can go wrong, members realize the importance of self-managing their COPD to prevent serious problems. • Back Pain Management Program. This program is designed to help members with chronic back pain understand their condition and what they can do to protect their back. The program focuses on back care education, exercise, pain management and measures to deal with the anxiety and/or depression that may accompany back pain • Cholesterol Management Program. The Cholesterol Management Program is targeted for members eighteen (18) to seventy-five (75) years of age who have experienced a heart attack and/or coronary artery bypass graft surgery (CABG), or a balloon angioplasty. This program is designed to teach members the importance of managing cholesterol. 	<p>Nothing.</p>

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

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Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your 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.

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Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) 	Nothing when we prior authorize your treatment.

Surgical procedures - continued on next page

Surgical procedures <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • 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.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> • <i>Neonatal circumcisions</i> • <i>Any services determined to be not medically necessary by KHP Central</i> 	<i>All charges.</i>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery 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: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance of breasts; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	Nothing when we prior authorize your treatment.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> • <i>Any services determined to be not medically necessary by KHP Central</i> 	<i>All charges.</i>

Oral and maxillofacial surgery	You pay
<p>Oral and maxillofacial surgical procedures include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. <p>NOTE: If you receive services on an inpatient basis, your doctor must obtain prior authorization from us before we will cover your surgery.</p>	<p>Nothing.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>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 tempormandibular joint (TMJ) pain dysfunction syndrome</i> 	<p><i>All charges.</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Adrenal-to-brain • Cornea • Heart • Heart/lung • Islet cell autotransplantation • Kidney • Kidney/Pancreas • Liver • Lung and lobar lung • Multivisceral • Pancreas/kidney • Small bowel • Small bowel/liver • Solitary Pancreas 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. 	<p>Nothing when we prior authorize your treatment.</p>

Organ/tissue transplants – continued on next page

Organ/tissue transplants <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses</i> • <i>Transplants not listed as covered</i> • <i>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.</i> • <i>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.</i> 	<p><i>All charges.</i></p>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Nothing when we prior authorize your treatment.</p>

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

Here are some important things you should keep in mind about these benefits:

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, Your 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 in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR ALL HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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Benefit Description	You pay
<p>Inpatient hospital</p> <p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>\$200 per admission (prior authorization required)</p>

Inpatient hospital - continued on next page.

Inpatient hospital <i>(continued)</i>	You pay
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood or 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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care unless medically necessary</i> • <i>Take-home items</i> • <i>Whole blood, blood plasma or blood components</i> 	<i>All charges.</i>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • 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 <p>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.</p>	Nothing when we prior authorize your treatment.
<ul style="list-style-type: none"> • <i>Not covered: Whole blood, blood plasma and blood components</i> 	<i>All charges.</i>

Extended care benefits/Skilled nursing care facility benefits	You pay
<p>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 physician and approved by us. We cover all necessary services including but not limited to:</p> <ul style="list-style-type: none"> ▪ 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 physician. 	\$200 per admission (prior authorization required)
<ul style="list-style-type: none"> • <i>Not covered: Custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.</i> 	<i>All charges.</i>
Hospice care	
<p>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 physician, who certifies that you are in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing when we prior authorize your treatment.
<ul style="list-style-type: none"> • <i>Not covered: Independent nursing, homemaker services, and inpatient hospice care.</i> 	<i>All charges.</i>
Ambulance	
<p>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.</p>	Nothing when we prior authorize your treatment or when medically necessary in connection with an emergency service.
<ul style="list-style-type: none"> • <i>Not covered: ambulance services when not medically necessary or not authorized by us.</i> 	<i>All charges.</i>

Section 5(d) Emergency services/accidents

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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.

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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. Contact your PCP after receiving Emergency treatment but before receiving follow-up care. Please note that your PCP must coordinate follow-up care for it to be covered by KHP Central. 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).

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.

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 after receiving emergency treatment but before receiving follow-up care.

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 after receiving emergency treatment but before receiving follow-up care.

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: Medical care is available through KHP Central PCPs seven days a week, 24 hours a day. Urgent care services within our service area must be provided by or otherwise coordinated by your PCP. 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 our 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 three 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 PCP to inform them of the visit. You must contact your PCP prior to receiving care under BlueCard Follow-Up care. If necessary, your PCP will coordinate services under BlueCard Follow-Up Services. All follow-up services must be coordinated by your PCP. If you do not contact your PCP before receiving follow-up services, the services will not be covered by KHP Central. 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 PCP coordinates the service.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office 	\$15 per PCP office visit during normal office hours; \$25 per PCP office visit after hours usually scheduled for appointments.
<ul style="list-style-type: none"> • Emergency care at an urgent care center 	\$50 per visit; \$15 if you are referred by your PCP and the service could have been provided in the PCP's office.
<ul style="list-style-type: none"> • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$50 per visit; \$15 if you are referred by your PCP and the service could have been provided in the PCP's office. Copayment waived if we authorize your admittance. However, if you are admitted, you will pay a \$200 inpatient copayment.
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges when we do not prior authorize your treatment.</i>

Emergency outside our service area	You pay
<ul style="list-style-type: none"> • 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.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges when we do not prior authorize your treatment.</i>
Ambulance	
<p>Professional ambulance service when medically appropriate. These include, but are not limited to:</p> <ul style="list-style-type: none"> • Air ambulance • Basic life support • Advanced life support • Invalid coach service <p>Note: See 5(c) for non-emergency service.</p>	You pay nothing when we authorize your treatment.
<p><i>Not covered: ambulance services when not medically necessary or not authorized by us.</i></p>	<i>All charges.</i>

Section 5(e) Mental health and substance abuse benefits

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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:

- 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.
- 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 PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>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.</p> <p>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.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$20 per Specialist office visit.</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you.</p> <p>\$15 per PCP office visit or \$20 per Specialist office visit if you must have an office visit to receive these services.</p>

Mental health and substance abuse benefits – continued on next page.

Mental health and substance abuse benefits <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	\$200 copayment per inpatient admission.
<p><i>Not covered: Services we have not approved.</i></p> <p><i>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.</i></p>	<i>All charges.</i>

Your mental health and substance abuse treatment, which is also referred to as behavioral health services, is provided through a subcontract with PacifiCare Behavioral Health, Inc. (PBH), 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 \$20 for each outpatient counseling visit is required.

Contacting Your Mental Health Provider.

Prior to accessing non-Emergency services, you must contact PacifiCare Behavioral Health at 1-800-216-9748 (TDD number at 1-888-877-5378). Through a brief telephone conversation, PBH personnel will help identify your individual needs. They will ask questions to better understand your cultural (linguistic, age, gender), clinical (type of concern such as depression, chemical dependency), and geographic (where you live or work) needs. Using this information, PBH will provide you with the names of providers who can best meet your needs. The PBH Provider you choose will be responsible for providing and/or coordinating your mental health/chemical dependency treatment. For outpatient non-emergency services to be covered, the services must be received from a PBH network provider and must have a prior notification to PBH. A listing of all participating mental health and chemical dependency providers is included in the KHP Central Participating Physicians, Pharmacies, and Hospitals Directory and its updates, and on KHP Central's website at www.khpc.com.

If you are faced with a crisis, contact PBH at 1-800-216-9748 (TDD number 1-888-877-5378). PBH's Care Managers and network providers are available twenty-four (24) hours a day, seven (7) days a week, to offer assistance and coordinate care.

PBH also offers translator services to its non-English speaking Members. To access this service, simply call PBH.

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 after receiving these services but before receiving follow-up care.

Limitation

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

Section 5(f) Prescription drug benefits

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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 the next page.
- 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.

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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 (please refer to the 'These are the dispensing limitations' information below).

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 or on KHP Central's website, www.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: KKeystone Health Plan Central, P.O. Box 779855, Harrisburg, PA 17177-9855, or via fax at 1-866-405-6382. 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.

Certain injectable medications must be obtained through Priority Healthcare, an Express Scripts participating pharmacy specializing in injectable medications. Priority Healthcare will dispense these injectable medications to you following receipt of a prescription from your physician. Your physician will submit your prescription for your injectable medication to Priority Healthcare along with your insurance information and delivery instructions. In addition, your physician will request prior authorization, if required. You will not be able to obtain these injectable medications from participating retail pharmacies or from the Express Scripts mail service pharmacy.

Priority Healthcare will dispense up to a thirty (30) day supply of injectable medications at one time. This helps to avoid sending you drugs you may not need because your physician changes your medication or changes the amount you should take. Priority Healthcare usually ships your medication overnight via UPS or Federal Express within twenty-four (24) hours of receiving your prescription. Prior to delivery, a Priority Healthcare representative will call you to verify your delivery information and set up payment arrangements for your copayment or coinsurance.

If you have any questions regarding your injectable prescriptions that will be filled by Priority Healthcare, you may contact a Priority Healthcare Representative at 1-877-599-7751, Monday through Friday, between 8:30 a.m. and 6:00 p.m.

You may also contact a KHP Central Customer Service Representative at 1-800-622-2843 (TDD 1-800-699-7075), Monday through Friday, between 8:00 a.m. and 5:00 p.m.

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. KHP Central will provide you with written updates to the drug formulary.

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, visit KHP Central's website at www.khpc.com, call KHP Central's Customer Service Department at 1-800-622-2843 or [Express Scripts' Customer Service Department at 1-800-844-0719](tel:1-800-844-0719).

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 the 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. If you are in the military and called to active duty due to an emergency, please contact us if you need assistance in filling a prescription before your departure.

Some medications are authorized to be dispensed for a specific quantity over a certain day supply. Specific therapy limitations are set based on the manufacturer or Food and Drug Administration recommended dose and duration of treatment and may be based on specific prescription drug benefit plan design.

Prescription drugs (continued)

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 KHP Central's website at www.khpc.com. KHP Central will provide you with written updates to the prior authorization list.

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. The requestor (the prescribing physician and/or dispensing pharmacy) will be initially notified via phone or fax of the decision within two (2) working days from the date Express Scripts received all applicable information.

If the medication is authorized, the approval decision will also be confirmed and communicated in writing to you within two (2) working days 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 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 58 of this brochure for information on filing a grievance with us.

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan provider and obtained from a Plan pharmacy or through our mail service pharmacy:</p> <ul style="list-style-type: none"> • Drugs on the KHP 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 • Drugs for Growth Hormone Therapy 	<p>At a participating pharmacy:</p> <ul style="list-style-type: none"> ▪ 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. <p>From the Express Scripts mail service pharmacy:</p> <ul style="list-style-type: none"> ▪ A \$20 (generic)/ \$50 (preferred brand)/ \$80 (non-preferred brand) copayment for up to a 90-day supply per prescription unit or refill. <p>Note:</p> <ul style="list-style-type: none"> ▪ 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 on next page

Covered medications and supplies <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Drugs for erectile 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. <p>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.</p>	<p>50% coinsurance.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs that do not legally require a written prescription from a health care professional licensed to prescribe drugs (other than insulin)</i> • <i>Drugs that have an over-the-counter (non-prescription) equivalent</i> • <i>Nutritional or dietary supplements including vitamins and nutritional supplements available without a prescription</i> • <i>Medical supplies such as dressings and antiseptics, except diabetic supplies as indicated on the benefit list</i> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs used in conjunction with non-covered medical services</i> • <i>Drugs to enhance physical or athletic performance</i> • <i>Drugs to promote weight loss, except for treatment of morbid obesity*</i> • <i>Drugs which are investigational or experimental in nature, as determined by KHP Central</i> • <i>Immunization agents, biological sera, blood or blood product</i> • <i>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</i> • <i>Venoms, allergy serums and desensitization serums</i> • <i>Smoking Cessation drugs and products *</i> • <i>Drugs prescribed and administered in the provider's office</i> • <i>Replacement prescription resulting from loss, theft, or damage</i> • <i>Except in emergency situations, drugs purchased from a non-participating pharmacy</i> • <i>Request for reimbursement filed more than ninety (90) days after the pharmacy receipt date</i> • <i>Select newly Food and Drug Administration approved drugs for the first six months of availability for which the determination regarding medical necessity and/or other protocols regarding coverage or determinations regarding non-coverage may require analysis by KHP Central</i> • <i>Dental washes and rinses</i> • <i>Drugs that are restricted through the clinical process of the KHP Central drug formulary system, such as, but not limited to, the prior authorization process</i> <p><i>*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.</i></p>	<p><i>All charges.</i></p>

Section 5(g) Special features

Feature	Description
<p>BlueCard Urgent Care – Out of Area Services</p>	<p>If you are traveling outside the Plan’s service area and require urgent care, you need to use the following procedure:</p> <ul style="list-style-type: none"> • 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 KHP Central Medical ID card and pay the applicable copayment while you are at your appointment. • You must contact your PCP 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. <p>In the event of an Emergency: The member seeks immediate assistance at the nearest medical facility. The member should contact his or her PCP after the incident so that necessary follow-up care can be arranged.</p>
<p>Away From Home Care -Guest Membership</p>	<p>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 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.</p> <p>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.</p> <p>Not all geographic areas within the United States participate in the Guest Membership Program. Please contact KHP Central’s Customer Service Department at 1-800-622-2843 (TDD 1-800-669-7075) to find out if the geographic area where you or your dependents will be staying participates in the Guest Membership Program and to find out if you or your dependents are eligible for the Guest Membership Program.</p> <p>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.</p> <p>If a dependent of a subscriber would otherwise be an eligible dependent, but permanently resides outside of the KHP Central service area in an area where a Guest Membership Program is not available, the dependent is not eligible for coverage.</p>

<i>Keeping Well</i>	You will receive KHP Central member newsletters to keep you updated on health-related topics of seasonal interest as well as to inform you of updates to your coverage with us.
Health Information Line	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 health related topics.
<u>www.khpc.com</u>	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

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

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- 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 dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when certain non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover 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.

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Accidental injury benefit	You pay
<p>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 (unintentional traumatic) injury to the jaw or structures contiguous to the jaw, including accidental injury to the teeth. We cover only those medically necessary services immediately required in response to the emergency and to stabilize your condition. We do not cover accidental injuries resulting from chewing or biting or injuries resulting from dental disease.</p>	<p>Nothing</p>

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.

Health and Fitness 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 you improve and maintain your overall health, we've negotiated discounts for health and fitness services at the facilities within the KHP Central service area. This information is available from KHP Central in hard copy or on our website. Participating facilities are listed alphabetically by county and by type of service. 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 13-15.**

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 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;
- 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;
- Services related to or rendered in connection with a non-covered service;
- Charges for your failure to keep a scheduled appointment or for any charges associated with your decision to cancel an elective surgery; or
- Services you receive that are provided by a relative for which, in the absence of coverage, no charge would be made.
- Membership dues, subscription fees, charges for service policies, insurance premiums and other payments analogous to premiums which entitle enrollees to services, repairs, or replacement of devices, equipment or parts without charge or at a reduced charge.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain 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 most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. 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. When you must file a claim – such as for services you receive outside the Plan’s service area – submit it on the HCFA-1500 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 779855, Harrisburg, PA 17177-9855 or via fax at 1-866-405-6382.

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 779855, Harrisburg, PA 17177-9855 or via fax at 1-866-405-6382.

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/prior approval:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Keystone Health Plan Central, FEP Denial Reconsideration Committee, P.O. Box 779869, Harrisburg, PA 17177-9869; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

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.

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

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 approval, 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 approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202-606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under 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 or 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.

• Should I enroll in Medicare?

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

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

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

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

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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 claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-800-622-2843 or see our website at <http://www.khpc.com>*

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

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

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

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

• **Medicare Advantage**

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

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

you:

This Plan and our Medicare Advantage plan: You may be eligible to enroll in our Medicare Advantage plan, SeniorBlue, based on your zip code and county of residence. Please call 1-800-990-4201 (TDD 1-800-779-6961) for more information.

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

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

TRICARE and CHAMPVA

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under 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. You may also be responsible for additional amounts. See page 16.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page xx.
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, device, 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: <ul style="list-style-type: none">• 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

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, 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 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 Benefit 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 Plan’s Basic Option.

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2004 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **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 provide 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 Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12.Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

• What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you and your spouse, if married, can work, look for work or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- Online: visit www.FSAFEDS.com and click on **Enroll**.
- Telephone: call and FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337) Monday through Friday; from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work..

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006, to submit claims for eligible expenses.

The FSAFEDS Calculator at www.fsafeds.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page xx and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the High Option of this plan, typical out-of-pocket expenses include: *[NOTE TO PLAN: List the 3 most frequent/significant expenses that are subject to deductibles, coinsurance and/or copayments, then list 3 common but significant expenses not covered by the Plan.]*

Under the Standard Option of this plan, typical out-of-pocket expenses include: *[NOTE TO PLAN: List the 3 most frequent/significant expenses that are subject to deductibles, coinsurance and/or copayments, then list 3 common but significant expenses not covered by the Plan.]*

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS website at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

• Tax savings with an FSA

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

- **Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

{Note to Plan: delete this section if you do not participate in paperless reimbursement.}

- **Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the [Dependent Care Tax Credit Worksheet](#) from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account. (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS website** at www.fsafeds.com, or contact SHPS by email or by phone. SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: fsafeds@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

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

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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- 2005

- **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: \$15 primary care; \$20 specialist	19
Services provided by a hospital:		
Inpatient	\$200 copayment per admission	38
Outpatient	Nothing	39
Emergency benefits		
In-area	\$50 copayment per emergency room visit	42
Out-of-area.....	\$50 copayment per emergency room visit	43
Mental health and substance abuse treatment	Regular cost sharing	44
Prescription 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	49
For up to a 90-day supply per prescription unit or refill for generic drugs or name brand drugs		
Dental care	Nothing	54
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.		
Vision care	No benefits.	26
Special features: BlueCard Urgent Care – Out of Area Services; Away From Home Care-Guest Membership; <i>Keeping Well</i> ; Health Information Line; and www.khpc.com .		52
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	We do not have an out-of-pocket maximum.	16

Notes

2005 Rate Information for Keystone Health Plan Central

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

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

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

		Non-Postal Premium				Postal Premium	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	S41	\$131.08	\$77.13	\$284.01	\$167.11	\$154.74	\$53.47
Self and Family	S42	\$298.23	\$198.56	\$646.17	\$430.21	\$352.08	\$144.71