



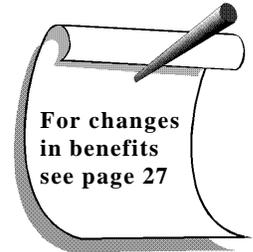
Keystone Health Plan Central

1999

A Health Maintenance Organization



This Plan has full accreditation
from the NCQA, April 1997 - April 2000.
See the 1999 FEHB Guide for more
information on NCQA.



Serving: The Lehigh Valley, Northern Tier and Harrisburg, Pennsylvania areas
Enrollment in this Plan is limited; see page 10 for requirements.

Enrollment code:

- S41 Self only**
- S42 Self and family**

Visit the OPM website at <http://www.opm.gov/insure>
and
this Plan's WEB page at <http://www.khpc.com>

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United States
Office of
Personnel
Management



RI 73-241

Keystone Health Plan Central

Keystone Health Plan Central, Inc., P.O. Box 898812, Camp Hill, Pennsylvania 17089-8812 has entered into a contract (CS 2076) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Keystone Health Plan Central, KHPC, or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on page (xx) of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 1-800/622-2843 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

**THE HEALTH CARE FRAUD HOTLINE
202/418-3300**

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

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

General Information

Confidentiality

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

If you are a new member

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

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

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor** except in the case of emergency as described on pages 17, 18. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hospitalized" on page 16.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

General Information *continued*

If you are hospitalized

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

Your responsibility

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

Things to keep in mind

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

General Information *continued*

- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. See page 22 for information on the Medicare prepaid plan offered by this Plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

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

Former spouse coverage

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

Temporary continuation of coverage (TCC)

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

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

General Information *continued*

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

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

Notification and election requirements

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

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

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

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

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

Conversion to individual coverage

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

General Information *continued*

Certificate of Creditable Coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Facts about this Plan

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

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

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

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at (800/622-2843) or you may write the Carrier at P.O. Box 898812, Camp Hill, PA 17089-8812. You may also contact the Carrier by fax at 717/975-6895, at its website at <http://www.khpc.com>.

Information that must be made available to you includes:

- Disenrollment rates for 1997
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the Carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Who provides care to Plan Members?

Keystone is an Individual Practice Prepayment (IPP) Plan. Each member selects a primary care to doctor from among the Plan's participating Family Practitioners, Internists, and Pediatricians. There are approximately **356** participating primary care doctors in the Lehigh Valley service area, and approximately 991 participating primary care doctors in the Harrisburg service area, and approximately 172 primary care doctors in the Northern Tier service area. Keystone Members and their dependents must select a primary care doctor from within the service area in which they are enrolled. These primary care doctors will deliver basic health services to Plan Members in their own conveniently located offices. Additionally, they will arrange for necessary specialty and hospital care at one of the many participating specialists' offices or participating hospitals throughout the Plan's service areas.

Facts about this Plan *continued*

Role of a primary care doctor

When you enrolled in Keystone, you selected a PCP to be your personal doctor. He or she is the focal point of your health-care and is the medical professional qualified to treat you for most of your health-care needs. If your PCP decides you need the services of a specialist (a cardiologist or a surgeon, for example), diagnostic testing (including laboratory services) or hospitalization, he or she will refer you to an appropriate specialist or facility. If your PCP refers you to a specialist, diagnostic testing center, hospital, or any other doctor or facility, be sure to obtain a referral form from your PCP before you go for services. Give the form to the doctor or facility to whom you have been referred before receiving services. This form will indicate the services your PCP has Authorized. Services of other providers are covered only when you have been referred by your primary care doctor, with the following exception: a woman may see her Plan gynecologist for her annual routine examination without a referral. State law provides coverage for nurse midwives.

When you arrive for your appointment, show your Keystone identification card. If you cannot keep your appointment, please be sure to call with your cancellation as soon as possible, so your scheduled time can be used by someone else. Your PCP has the right to charge you for a missed appointment you did not cancel. This charge will not be paid by Keystone.

You will not be charged for Covered Services provided by your PCP, except for any applicable Copayments. If you receive a bill for any other charges, please call our Member Service Department at (717) 763-3894 or 1-800-622-2843 toll-free in Pennsylvania (TDD number at 1-800-669-7075 for the hearing impaired.)

Choosing your doctor

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Services Department at 1-800/622-2843; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. **Important note: When you enroll in this plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.**

Should you decide to enroll, you will be asked to complete a primary care doctor selection form and send it directly to the Plan, indicating the name of the primary care doctor(s) selected for you and each member of your family. Members may change their doctor selection by notifying the Plan 30 days in advance.

If you are receiving services from a doctor who leaves the Plan, the Plan will provide payment for covered services until the Plan can make reasonable and medically appropriate provisions for the assumption of such services by a participating doctor.

Facts about this Plan *continued*

Referrals for specialty care

If your PCP determines that you need specialized services, you will be referred to the appropriate specialist or facility.

Your PCP will give you a referral form for Medically Necessary care. This form indicates the services to be performed and provides Authorization for the specialist or facility to provide the requested services. The specialist or facility must contact the PCP before providing additional services not listed on the form, or for a change in diagnosis. In some cases, you will be required to obtain an additional referral form from the PCP. It is important to note that all laboratory services must be performed using the PCP's laboratory arrangement listed on your ID card.

Certain services require Authorization through Keystone's Utilization Management Department. The physician is required to contact Keystone before providing such services.

Retroactive referrals are not permitted by Keystone. You must obtain the referral before receiving services.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist. The treatment plan will permit you to visit your specialist without the need to obtain further referrals.

Referrals for mental conditions/ substance abuse benefits

Keystone Members may now access GreenSpring by calling 1-800-688-1911. GreenSpring will direct the Member to the appropriate mental health or substance abuse provider and the Member may go directly to receive care. Members may also call Keystone or their PCP to determine the aligned provider. Upon arrival at their first appointment, the Member will be requested to complete an authorization to release information to the PCP (and other necessary paper work).

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor must obtain the Plan's determination of medical necessity before you may be hospitalized, referred for specialty care or obtain follow-up care from a specialist.

For new Members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. If the doctor originally referred you prior to your joining the Plan is now your Plan primary care doctor, you need only call to explain that you now belong to this Plan and ask that a "referral form" be sent to the specialist for your next appointment.

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

Hospital care

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

Out-of-pocket maximum

Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments required for a few benefits.

Facts about this Plan *continued*

Deductible carryover

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

Submit claims promptly

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

Experimental/investigational determinations

Any treatment, procedure, facility, equipment, drug, drug application or drug usage device, or supply which KHP Central, relying on the advice of the general medical community, including, but not limited to, medical consultants, medical journals and/or governmental regulations, is not accepted as standard medical treatment for the condition being treated, and/or any such items requiring federal or other governmental agency approval which approval has not been granted at the time the services were rendered or requested.

Other considerations

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

The Plan's service areas

The service area for this Plan, where Plan providers and facilities are located, is described below. You must live or work in the service area to enroll in this Plan.

The service area for this Plan includes the following areas:

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

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

Northern Tier: The Pennsylvania Counties of Columbia, Center, Juniata, Mifflin, Montour, Northumberland, Snyder and Union.

Benefits for care outside the service area are limited to emergency services as described on page 17.

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

Facts about this Plan *continued*

Reciprocity

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

Local Guest Membership

Your away-from-home travel isn't always measured in day trips or week vacations. That's why we also provide care when someone's away a long time, whether it's extended out-of-town business, semesters at school or families living apart. For anyone away at least 90 days, we offer *Guest Membership* at an affiliated HMO near your travel destination. Guest Membership allows you or your family to enjoy the full range of benefits offered by the Host HMO. For more details, please contact Keystone at 1-800-622-2843 and ask to speak with the HMO Blue-USA Guest Coordinator.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is the official statement of benefits on which you can rely.

Circumstances beyond Plan control

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

Arbitration of claims

Any claim for damages for personal injury, mental disturbance or wrongful death arising out of the rendition of or failure to render services under this contract must be submitted to binding arbitration.

Other sources of benefits

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

Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, unless you use Plan providers. You must tell you Plan that you or your family member is eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

General Limitations *continued*

Group health insurance and automobile insurance

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

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

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

CHAMPUS

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

Medicaid

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

Workers' compensation

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

DVA facilities, DoD facilities, and Indian Health Service

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

General Limitations *continued*

Other Government agencies

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

Liability insurance and third party actions

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

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition as discussed under Authorizations on page 9.** The following are excluded:

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

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; \$10 copay. There will be a \$20 copay for visits to a doctor's office after normal hours. Within the service area, house calls will be provided if, in the judgement of the Plan doctor, such care is necessary and appropriate; you pay nothing for a doctor's house call, or for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 and above, one mammogram every year. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters (copay waived for children up to age 18)
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Medical and Surgical Benefits *continued*

- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor (office visit copays are waived for obstetrical care). The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum); excluding poison ivy injections
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, heart-lung, kidney, liver, lung (single or double), and pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Transplants are covered when approved by the Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Orthopedic devices, such as braces; foot orthotics
- Prosthetic devices, such as artificial limbs and intraocular lenses following cataract removal
- Durable medical equipment, such as wheelchairs and hospital beds
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you.

Limited benefits

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Medical and Surgical Benefits *continued*

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

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

Diagnosis and treatment of infertility is covered; you pay 50% of the charges. The following types of **artificial insemination** are covered; intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI); you pay 50% of the charges; cost of donor sperm is not covered. Artificial insemination is not a covered service when it is used to achieve pregnancy in a woman whose spouse has had voluntary sterilization. Fertility drugs are covered. Other **assisted reproductive technology (ART) procedures**, such as in vitro fertilization and embryo transfer, are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at a Plan facility for up to 60 days; you pay nothing.

Chiropractic services are limited to acute care (severe and sudden onset within 72 hours of the accident or injury) and are provided for up to two weeks. Services are limited to X-rays, consultations and manipulation. Chronic problems and routine maintenance are not covered.

What is not covered

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Hospital/Extended Care Benefits

What is covered

Hospital care

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

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

Extended care

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

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

Hospice care

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

Ambulance service

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

Limited benefits

Inpatient dental procedures

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

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See pages 19, 20 for nonmedical substance abuse benefits.

What is not covered

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Emergency Benefits

What is a medical emergency?

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

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

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

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

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

Plan pays...

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

You pay...

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

Emergencies outside the service area

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

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

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

Plan pays..

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

You pay...

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

Emergency Benefits *continued*

What is covered

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

What is not covered

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

Filing claims non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 23, 24.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

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

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 20 outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year, **you pay** a \$25 copay for each covered visit - all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** nothing for the first 30 days - all charges thereafter.

What is not covered

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

Substance abuse

What is covered

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

Alcoholism Benefits

Outpatient care

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

Inpatient care

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Mental Conditions/Substance Abuse Benefits *continued*

Other Substance Abuse Benefits

Outpatient care

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

Inpatient care

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

What is not covered

- Rehabilitation services in an acute care hospital, except for alcohol abuse
- Treatment that is not authorized by a Plan doctor

Prescription Drug Benefits

What is covered

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

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

Maintenance Drugs: Maintenance drugs (drugs used to treat chronic or long term conditions) may be dispensed for up to a 90-day supply at a participating pharmacy. **You pay** a \$10 copay for a 30-day supply, or a \$20 copay for a 60-day supply, or a \$30.00 copay for a 90-day supply per prescription unit or refill.

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

Formulary: Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Nonformulary drugs will be covered when prescribed by a Plan doctor. However, the participating pharmacies will not dispense non-formulary medications unless there is plan approval.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Oral contraceptive drugs
- Insulin
- Diabetic supplies including syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent and acetone test tablets
- Disposable needles and syringes needed to inject covered prescribed medication
- Compounded preparations containing at least one prescription drug

Limited benefits

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Prescription Drug Benefits *continued*

What is not covered

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

Other Benefits

Dental care

Accidental injury benefit

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Non-FEHB Benefits Available to Plan Members

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

Vision Care

Locations within our service area offer discounts to Keystone Health Plan Central Members. Details can be found in the Health and Fitness/Vision Centers sections of the Participating Physicians, Pharmacies, and Hospitals listing. Members should present their Plan identification card to obtain services.

Fitness Discount Programs

Area health clubs, smoking cessation programs and weight reduction programs offer discounts to Keystone Health Plan Central Members. Members will find a list of participating organizations in the Plan's Standard Benefits and Optional Services Brochure. Members present their Plan identification card to obtain discounts.

NurseLink

Keystone Health Plan Central is pleased to offer our valued Members a unique service that offers access to professional health information 24 hours a day, 365 days a year. It's called NurseLink, and it is here for our Members. With just one toll-free call, Members can either speak with a registered nurse or access our health information library, an over-the-phone audio system providing access to over 1,100 health-related topics. Members will receive a booklet describing NurseLink, listing the health information topics, and including wallet cards with the toll-free number so that they may contact NurseLink anywhere, at any time. NurseLink is just one of the many ways in which Keystone Health Plan Central is continually working to improve our Members' health care. For more information on NurseLink, please call (717) 763-3894 or (800) 622-2843.

Wellness Programs - As a "managed care" program, one of the objectives of Keystone is to provide Members with the resources to stay healthy. The following are features of the programs available to those who enroll in our plan:

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

For more information regarding these programs, please contact member services at 1-800-622-2843.

Medicare prepaid plan enrollment

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

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

Benefits on this page are not part of the FEHB contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Membership Services Office at 1-800/622-2843 or you may write to the Plan at P.O. Box 898812, Camp Hill, PA 17089-8812. You may also contact the Plan by fax at 717/975-6895, at its website at <http://www.khpc.com>.

Disputed claims review

Plan reconsideration

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

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

OPM review

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

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

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

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

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

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

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

How to Obtain Benefits *continued*

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

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

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

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

How Keystone Health Plan Central Changes January 1999

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

Program-wide Changes:

Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.

- If you have a chronic, complex or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist, without the need to obtain further referrals (See page 9).
- A medical emergency is defined as the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care (See page 17).
- The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 20 outpatient Mental Conditions visit limit.

Changes to this Plan:

- The copay for a doctor's office visit is now \$10 per visit. Previously, the copay was nothing. See page 13.
- The copay for a doctor's office visit after hours is now \$20 per visit. Previously, the copay was \$10. See page 13.
- The copay for immunizations for children under age 18 is waived. Previously, there was no need to waive the copay as there was no office visit copay. See page 13.
- The supply period for prescription drugs applicable for each copay is now up to a 30-day. Previously, the supply period applicable to each copay was up to a 31-day supply. See page 20.
- The copay for prescription drugs obtained through the Plan's mail order option is now \$20 per prescription unit or refill. Previously, there was no copay when the mail order option was utilized.
- Mammograms are now covered once annually for female Members age 40 and over. Previously, mammograms for female Members were covered less frequently depending on the member's age.

How Keystone Health Plan Central Changes January 1999 *continued*

- Generic enforcement now applies to obtaining prescription drugs. This means that generic drugs will be dispensed instead of brand name drugs when permissible and when the prescribing doctor does not require the name brand drug. If a member requests a brand name drug when generic substitution is permissible and the prescribing doctor does not require the brand name drug, the member now pays the prescription drug copay and the cost difference between the brand name drug and its generic equivalent. Previously, generic enforcement did not apply and Members did not have to pay the cost difference for brand name drugs. See page 20.
- Changes have been made for obtaining referrals for both Specialty and Mental Conditions/Substance Abuse Benefits that should make the plan easier for Plan Members to access care and will add to the ease of administration for providers. Refer to page (9) for more detail.
- HMO Blue-USA provisions have been added, which includes Guest Membership for anyone away from the Plan's service area for at least 90 days. Guest Membership offers the opportunity to obtain medical services at an affiliated HMO near your travel destination. Refer to page (11) for more detail.
- The Plan's service area has been expanded to include Lancaster County, Pennsylvania.

Summary of Benefits for Keystone Health Plan Central - 1999

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

	Benefits	Plan pays/provides	Page
Inpatient care	Hospital	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing	16
	Extended care	All necessary services, no dollar or day limit. You pay nothing	16
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. You pay nothing	19
	Substance abuse	For alcoholism, up to 30 days per year for abuse rehabilitation, lifetime maximum of 90 days. For other substance abuse, one 28-day confinement per year for rehabilitation, lifetime maximum of two confinements. You pay nothing	19, 20
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay \$10 per office visit, or for house calls by a doctor	13
	Home health care	All necessary visits per calendar year by nurses and health aides. You pay nothing	14
	Mental conditions	Up to 20 outpatient visits per year. You pay a \$25 copay per visit	19
	Substance abuse	For alcoholism, up to 60 visits per year for rehabilitation, lifetime maximum of 120 visits; you pay nothing for the first course of treatment then a \$25 copay per full visit or a \$15 copay per partial visit. For other substance abuse, up to 30 visits per year. You pay a \$25 copay per visit	19, 20
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay a \$25 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan	17, 18
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay a \$10 copay per prescription (generic or brand) (oral contraceptives included) per 30-day supply, generic enforcement, 3 times copay for 90-day supply. Mail order "maintenance" drugs (oral contraceptives included) 90-day supply, generic enforcement.	20, 21
Dental care		Accidental injury benefit; you pay nothing	21
Vision care		No current benefit	
Out-of-pocket maximum		Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for a few benefits	9

1999 Rate Information for Keystone Health Plan Central

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

Postal rates apply to most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	S41	\$72.06	\$25.17	\$156.13	\$54.54	\$84.98	\$12.25
Self and Family	S42	\$160.39	\$75.78	\$347.51	\$164.19	\$183.29	\$52.88