Keystone Health Plan Central

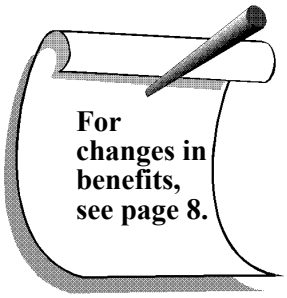
http://www.capbluecross.com

2009

A Health Maintenance Organization (high and standard option)

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

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



Enrollment code for this Plan:

- **S41 High Option – Self Only**
- **S42 High Option – Self and Family**
- **S44 Standard Option – Self Only**
- **S45 Standard Option - 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

Important Notice from Keystone Health Plan Central About

Our Prescription Drug Coverage and Medicare

OPM has determined Keystone Health Plan Central's prescription drug coverage is on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll n Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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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, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Keystone Health Plan Central.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the 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 fehbwebcomments@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:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits 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 1-866-987-2142 (TDD 1-800-669-7075) 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);
  - 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.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

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.

Visit these websites for more information on patient safety.

www.ahrq.gov/path/beactive.htm. 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/. 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. We give you a choice of enrollment in a High Option or Standard Option.

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 Web site (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 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 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.
- 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 the 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 Management Program as well as progress towards meeting goals.
- 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 1-866-987-2142 (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 717-703-8494. You may also visit our Web site at www.capbluecross.com, or communicate with us through *Capital BlueCross SecureMail*.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilizations) to any of your treating physicians or dispensing pharmacies.

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, Franklin, Fulton, Lancaster, Lebanon, Perry, Schuylkill and York.

Lehigh Valley: The Pennsylvania counties of Lehigh and Northampton.

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

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

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should 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 of 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 (name, 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 1-866-987-2142 (TDD 1-800-669-7075) and ask to speak to a Guest Membership Coordinator.

Section 2. How we change for 2009

Do not rely only on these change descriptions; this Section 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.

Changes to the High Option

- Your share of the non-Postal premium will increase for Self Only and Self and Family.
- You will now have coverage for two sessions of nutritional counseling for overweight children (must have diagnosis of obesity) for ages 0 thru 18 per benefit period. These visits are subject to your specialist copay of $20 (see page 34).

Changes to the Standard Option Plan

- Your share of the non-Postal premium will increase for Self Only and for Self and Family.
- You will now have coverage for two sessions of nutritional counseling for overweight children (must have diagnosis of obesity) for ages 0 thru 18 per benefit period. These visits are subject to your specialist copay of $35 (see page 34).

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 electronic enrollment system (such as 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 1-866-987-2142 (TDD 1-800-669-7075) or write to us at Keystone Health Plan Central, P.O. Box 779855, Harrisburg, PA 17177-9855. You may also request replacement cards through our Web site at www.capbluecross.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 Web site. You can view our Web site at www.capbluecross.com or call our customer service department at 1-866-987-2142 (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 Web site. You can view our Web site at www.capbluecross.com or call our customer service department at 1-866-987-2142 (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 1-866-987-2142 (TDD 1-800-669-7075), or search for a PCP on our Web site at www.capbluecross.com.

- **Primary care**

Your primary care physician (PCP) can be a general or family practitioner, internist of pediatrician. Your PCP 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 that you need the services of a specialist, diagnostic testing, or hospitalization, for example, he or she will refer you to an appropriate KHP Central participating provider.

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. 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 hours to obtain test results, prescription refills or for other non-urgent matters.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us at 1-866-987-2142 (TDD 1-800-669-7075). We will help you select a new one.

- **Specialty care**

If your PCP determines that you need specialized services, he or she will refer you to the appropriate participating provider. Some services will also require preauthorization from KHP Central. Referrals are valid only for the provider to whom you were originally referred. If you wish to change the specialist to whom you have been referred, contact your PCP.

Referrals. When your PCP refers you for medically necessary care, he or she will issue a referral. The referral notification will indicate the services to be performed by the specialist or facility and any specific time frame for which the referral is valid. The specialist or facility must contact the PCP before providing additional services not originally referred. 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 your PCP's laboratory arrangement which is 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.

When your PCP refers you to a participating provider, your PCP will issue a referral. A referral notification can be completed in a variety of ways such as by fax or by telephone through KHP Central's Provider Interactive Voice Response system. It is the responsibility of the PCP to complete and submit the referral notification to KHP Central.

Please refer to the enclosed listing of services that require referral notification (see page 15).

Certain services will also require KHP Central's preauthorization. Please consult the enclosed listing of services that require preauthorization. To avoid delays in claims payment we recommend you consult with your provider prior to having services rendered to ensure that he or she has obtained the proper preauthorization 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. In certain cases, a specialist may be designated to provide and coordinate your primary and specialty care. This standing referral must be obtained from you PCP. The referral provides the specialist with the ability to perform the treatment required for a specific episode of illness, and is valid for 365 days or until the end of the benefit period, whichever occurs first. The specialist may refer you for additional medical services such as durable medical equipment or outpatient surgeries. Laboratory services must follow the PCP's laboratory arrangement as indicated on your ID card. Please note that all preauthorization guidelines will still apply. Designations of specialists to provide and coordinate your primary and specialty care must be requested in writing and shall be approved pursuant to a treatment plan approved by KHP Central in consultation with you, your PCP and, as appropriate, the specialist.

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 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 provider. Please contact your obstetrical/gynecological specialist or your PCP if you are unsure whether your treatment is considered to be obstetrical or gynecological. If necessary, your obstetrical/gynecological specialist will refer you for medically necessary care, such as laboratory or diagnostic services. The obstetrical/gynecological specialist should notify your PCP of all services and treatment you receive. This will ensure the continuity of your care.

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

Mental Health and Substance Abuse Tretment. Your mental health and substance treatment,which is also referred to as behavioral health services, is provided by KHP Central's behavioral health vendor. You are eligible for a full range of services including inpatient care, partial hospitalization programs, intensive outpatient treatment, outpatient individual/family counseling and other levels of care appropriate to individual needs.

Prior to accessing behavioral health services that do not qualify as emergency services, you must contact KHP Central's behavioral health vendor at 1-800-216-9748. For outpatient non-emergency services to be covered, the services must be received from a network provider and must have prior notification by the behavioral health vendor. A list of all participating mental health and substance abuse providers can be found in our provider directory and on KHP Central's website at www.capbluecross.com.

If you are faced with a crisis, contact KHP Central's behavioral health vendor at 1-800-216-9748. Care Managers and network providers are available twenty-four (24) hours a day, seven (7) days a week, to offer assistance and coordinate care.

KHP Central's behavioral health vendor also offers translator services for its non-English speaking Members. To access this service, simply call the behavioral health vendor.

Inpatient Services-Mental Health or Substance Abuse. If a need for inpatient care is identified, the inpatient stay must be preauthorized by KHP Central's behavioral health vendor.

Emergency Services. Emergency services do not have to be preauthorized, but you or your family should contact your PCP or KHP Central's behavioral health vendor after receiving these services but before receiving follow-up care. Refer to section 5(d), *Emergency services/accidents*, for further information.

Here are some 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 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. However, please refer below for additional information regarding members that are receiving an active course of treatment for an acute episode of a chronic illness or for an acute medical condition.
- 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 are receiving an active course of treatment for an acute episode of a chronic illness or for an actue medical condition and lose access to your specialist because:
  - you are new to our Plan; or
  - we terminate our contract with your specialist for other than cause; or
  - your specialist terminates his/her contract with us; or

- we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
- we reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-866-987-2142 (TDD 1-800-669-7075). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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.

How to get approval for…

- **Your hospital stay**

Present your ID card to your health care provider when medical services or supplies are requested. Your provider will need to provide medical information on the proposed treatment to our Clinical Management Department. We will verify your eligibility, benefit coverage, and the medical necessity of the service being requested.

Your Plan primary care physician or specialist is responsible for obtaining preauthorization for your hospital stay. However, we recommend that you check with your treating provider to be sure that necessary approvals were obtained before receiving services. Preauthorization of elective admissions and selected services should be obtained at least two (2) weeks prior to the date of service.

Preauthorization requirements do not apply to services provided by a hospital emergency room provider. If an inpateint admission results from an emergency room visit, notification to us must occur within forty-eight (48) hours or two (2) business days of the admission. If the hospital is a participating provider, they are responsible for notifying us. If the hospital is a non-participating provider, you or a responsible party acting on your behalf is responsible for notifying us.

- **How to precertify an admission**

Present your ID card to your health care provider when medical services or supplies are requested. Your provider will need to provide medical information on the proposed treatment to our Clinical Management Department. We will verify your eligibility, benefit coverage, and the medical necessity of the service being requested.

Your Plan primary care physician or specialist is responsible for preauthorizing your admission. However, we recommend that you check with your treating provider to be sure that necessary approvals were obtained before receiving services. Preauthorization of elective admissions and selected services should be obtained at least two (2) weeks prior to the date of service.

Preauthorization requirements, do not apply to services provided by a hospital emergency room provider. If an inpatient admission results from an emergency room visit, notification to us must occur within forty-eight (48) hours or two (2) business days of the admission. If the hospital is a participating provider, they are responsible for notifying us. If the hospital is a non-participating provider, you or a responsible party acting on your behalf if responsible for notifying us.

- **Maternity care**

Present your ID card to your health care provider when medical services or supplies are requested.

Service for obstetrical and gynecological care do not require a referral from your PCP. You may contact the 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 provider. Please contact your obstetrical/gynecological specialist or your PCP if you are unsure whether your treatment is considered to be obstetrical or gynecological. If necessary, your obstetrical/gynecological specialist will refer you for medically necessary care, such as laboratory or diagnostic services. The obstetrical/gynecological specialist should notify your PCP of all services and treatment you receive. This will ensure the continuity of your care.

Your treating provider is responsible for obtaining preauthorization for your hospital maternity stay. However, we recommend that you check with your treating provider to be sure that necessary approvals were obtained before receiving services. Your provider will need to provide medical information on the proposed treatment to our Clinical Management Department. We will verify your eligibility, benefit coverage, and the medical necessity of the service being requested.

- **What happens when you do not follow the precertification rules when using non-network facilities**

All care performed by non-network providers and facilities require preauthorization. If preauthorization is not obtained, you will be financially responsible for the cost of the care and services provided.

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 prior 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 "preauthorization." Your physician must obtain preauthorization for the following services, which include, but are not limited to:

- All non-emergency inpatient admissions including acute care, long-term acute care, skilled nursing facilities, and rehabilitation hospitals;

- Behavioral health (mental health care/substance abuse)-all inpatient admissions, partial hospitalization, outpatient services, and intensive outpatient programs (Behavioral health phone numbers are listed on the member's ID card);
- Non-emergent air and ground ambulance transports;
- Durable medical equipment (DME), orthotic devices and prosthetic appliances for all purchases and repairs greater than or equal to $300 dollars, and all rentals where the purchase price would be greater than or equal to $300;
- Enhanced external counterpulsation (EECP);
- All testing for genetic disorders except: (1) standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and (2) state mandated newborn genetic testing;
- All high-tech, non-emergency imaging procedures including: MRIs (magnetic resonance imaging), MRAs (magnetic resonance angiography), CT (computerized tomography) scans, PET (positron emission tomography) scans, SPECT (single proton emission computerized tomography) scans, and all cardiac nuclear medicine studies, including nuclear cardiac stress tests;
- Home health care;
- Home infusion therapy;
- Outpatient infusion therapy of the following medications: Remicade (infliximad), Amevive (alefacept), Orencia (abatacept);
- All potentially experimental or investigational and reconstructive/cosmetic therapies and procedures;
- Laser treatment of skin lesions;
- Manipulation therapy (chiropractic and osteopathic);
- Office surgical procedures that are performed in a facility, including, but not limited to:
  - arthrocentesis; aspiration of a joint; colposcopy; electrodesiccation condylomata-complex; excision of a chalazion; excision of a nail-partial or complete; enucleation or excision of external thrombosed hemorrhoids; 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 (if a benefit); repair of lacerations, including suturing (2.5 cm or less); vasectomy; wound care and dressings (including outpatient burn care); intraocular injection for retinal pathology;
- Outpatient surgeries-All potentially reconstructive/cosmetic and experimental or investigational surgeries;
- Pulmonary rehabilitation programs;
- Rehabilitation therapies including physical medicine, occupational therapy, speech therapy, and respiratory therapy;
- Transplant evaluations and services. Preauthorization will include referral assistance to the Blue Quality Centers for Transplant network if appropriate;
- All care performed by a non-participating provider.

Your physician is responsible for obtaining preauthorization, however, we recommend that you check with your provider to be sure that necessary approvals were obtained before receiving services. Preauthorization of elective admissions and selected services should be obtained at least two (2) weeks prior to the date of service.

The above listing identifies those services that require preauthorization only as of January 1, 2009. This listing is subject to change. Please call us at 1-866-987-2142 (TDD 1-800-669-7075) if you have questions regarding the preauthorization of a particular service.

Services requiring referral notification

When your PCP refers you to a participating provider, your PCP will issues a referral for the following services:

- Specialty office visits
- Durable medical equipment, prosthetics and orthotics-all purchases/repairs where the unit cost is less than $300 and rentals where the purchase price would be less than $300
- Education/training
- Endoscopy, including colonoscopy studies
- Outpatient surgeries and services not requiring preauthorization
- Sleep studies

The above listing identifies those services that require referral notification only as of January 1, 2009. This listing is subject to change. Please call us at 1-866-987-2142 (TDD 1-800-669-7075) if you have any questions regarding the requirement of a referral notification of a particular service.

Note that certain services require prior approval from us. Please consult the information listed immediately above regarding services that require our prior approval.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayments

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

Examples if you have the **High Option** plan: When you see a primary care physician you pay a copayment of $15 per office visit or if you see a specialist you pay a copayment of $20 per office visit. If you are admitted to the hospital, you pay a copayment of $200 per admission.

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

Examples if you have the **Standard Option** plan: When you see a primary care physician you pay a copayment of $15 per office visit or if you see a specialist you pay a copayment of $35 per office visit. If you are admitted to the hospital, you pay a copayment of $100 per day up to a maximum of $500 per admission.

If you use an emergency room for emergency services you will pay a copayment of $75 per visit. This copayment is waived if you are admitted to the hospital at the time of the emergency. However, if you are admitted to the hospital you will pay a copayment of $100 per day up to a maximum of $500 per admission.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year medical deductible is $250 per person under the Standard Option. Under a family enrollment the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $750 under the Standard Option.
- We also have a separate calendar year deductible for prescription drug coverage for the Standard Option:
  - $50 per person; $150 per family

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. Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments, coinsurance and deductibles required for benefits.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

Section 5. High and Standard Option Benefits

See page 8 for how our benefits changed this year. Page 81 and page 82 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. 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 High and Standard Option benefits, contact us at 1-866-987-2142 (TDD 1-800-669-7075) or at our Web site at www.capbluecross.com.

Each option offers the following unique features:

High Option

- $15 office visit copayment; $20 specialist visit copayment; $50 emergency room visit copayment; $200 inpatient copayment (per admission); $50 copayment on high-tech imaging services.

Standard Option

- $15 office visit copayment; $35 specialist visit copayment; $75 emergency room visit copayment; $100 per day inpatient copayment up to a maximum of $500 per admission; $100 outpatient facility surgery copayment per episode; $250 deductible per person and a $750 deductible per family; $50 copayment on high-tech imaging services.

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

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.
- The calendar year deductible is: $250 per person ($750 per family) under the Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION OF SOME SERVICES.** Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization (see page 13).
- **YOUR PHYSICIAN MUST COMPLETE A REFERRAL NOTIFICATION FOR SOME SERVICES.** Please refer to the referral information shown in Section 3 to be sure which services require referral notification (see page 15).

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office	$15 per primary care physician office (PCP) 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.	$15 per primary care physician office (PCP) visit $35 per Specialist office visit $25 per office visit if you see your PCP for services during hours other than those regularly scheduled for appointment. (No deductible when a copayment is applied)
Professional services of physicians • In an urgent care center • During a hospital stay	$50 per visit Nothing for the professional services of physicians	$75 per visit Nothing for the professional services of physicians. (No deductible when a copayment is applied)
In a skilled nursing facility	Nothing for the professional services of physicians. You must obtain prior authorization for these services	Nothing for the professional services of physicians. You must obtain prior authorization for these services
• Office medical consultations • Second surgical opinion	$15 per PCP office visit $20 per Specialist office visit	$15 per PCP office visit $35 per Specialist office visit

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
		(No Deductible when copayment is applied)
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.	$15 per PCP visit $35 per Specialist visit $25 per visit if you see your PCP for services during hours other than those regularly scheduled for appointments. (No deductible when copayment is applied)
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $20 per Specialist office visit, if you must have an office visit to receive these services.	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or, $35 per Specialist visit, if you must have an office visit to receive these services. (No deductible when a copayment is applied and No deductible for outpatient laboratory services)
High-tech Imaging to include: • MRIs (magnetic resonance imaging) • MRAs (magnetic resonance angiography) • CT (computerized tomography) scans • PET (positron emission tomography) scans • SPECT (single proton emission computerized tomography) scans • All cardiac nuclear medicine studies Note: You must obtain prior authorization for any of the above services	$50 per visit	$50 per visit

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Preventive care, adult	**High Option**	**Standard Option**
Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - 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	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $20 per Specialist office visit, if you must have an office visit to receive these services.	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $35 per Specialist office visit, if you must have an office visit to receive these services. (No deductible when a copayment is applied)
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $20 per Specialist office visit, if you must have an office visit to receive this test.	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $35 per Specialist office visit, if you must have an office visit to receive this test. (No deductible when a copayment is applied)
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. Otherwise, $15 per PCP office visit or $20 per Specialist office visit, if you must have an office visit to receive this test.	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $35 per Specialist office visit, if you must have an office visit to receive this test. (No deductible when a copayment is applied)
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 and older, one every calendar year Members may self-refer to a participating provider for a mammogram, either screening or diagnostic.	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $20 per Specialist office visit, if you must have an office visit to receive this service.	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $35 per Specialist office visit, if you must have an office visit to receive this service.

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
		(No deductible when a copayment is applied and No deductible for screening mammograms)
Adult routine immunizations recommended by KHP Central Preventive Health Guidelines, including those endorsed by the Centers for Disease Control and Prevention (CDC):	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers your. Otherwise, $15 per PCP office visit or $20 per Specialist office visit, if you must have an office visit to receive these services.	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $35 per Specialist office visit, if you must have an office visit to receive these services. (No deductible when a copayment is applied)
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	Nothing
Not covered: • *Routine physical examinations, testing, immunizations, and/or preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, including but not limited to pre-marital examinations, physicals for college, camp, sports or travel.* • *Vision examinations for refractive corrections.*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by KHP Central Preventive Health Guidelines, including those recommended by the American Academy of Pediatrics	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $20 per Specialist office visit, if you must have an office visit to receive these services	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $35 per Specialist office visit, if you must have an office visit to receive these services. (No deductible for Pennsylvania mandated immunizations)

Preventive care, children - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Preventive care, children (cont.)	**High Option**	**Standard Option**
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $20 per Specialist office visit, if you must have an office visit to receive these services.	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $35 per Specialist office visit, if you must have an office visit to receive these services. (No deductible when a copayment is applied and No deductible for Pennsylvania mandated immunizations)
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.	Nothing	Nothing
Not covered: Vision examinations for refractive corrections	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care	Nothing	Nothing
Note: Here are some things to keep in mind: • Your doctor must obtain authorization for your normal delivery admission; see page 14 for other circumstances, such as extended stays for you and your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery, (you do not need to precertify the normal length of stay). We will extend your inpatient stay for you or your baby if medically necessary. See page 14 for other circumstances. • 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.	$200 inpatient copayment will apply	$100 per day inpatient copayment up to a maximum of $500 per admission will apply

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Maternity care (cont.)	**High Option**	**Standard Option**
• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing $200 inpatient copayment will apply	Nothing $100 per day inpatient copayment up to a maximum of $500 per admission will apply
Not covered: • *Routine sonograms to determine fetal age, size or sex.* • *Neonatal circumcisions.*	*All charges*	*All charges*
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover diaphragms, cervical caps, oral contraceptives, and self-injectable contraceptives under the prescription drug benefit. Note: Your physician cannot dispense the contraceptive form of Depo provera from the office. You must obtain it under the prescription drug program.	$15 per PCP office visit $20 per Specialist office visit if you must have an office visit to have these services	$15 per PCP office visit $35 per Specialist office visit if you must have an office visit to receive these services (No deductible when a copayment is applied)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs	50% of the cost of the treatment	50% of the cost of the treatment (coinsurance is applied after the deductible is met)

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Infertility services (cont.)	**High Option**	**Standard Option**
Note: We cover injectable and oral fertility drugs under the prescription drug benefit.	50% of the cost of the treatment	50% of the cost of the treatment (coinsurance is applied after the deductible is met)
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Services for dependent children regardless of age* • *Cost of donor sperm* • *Cost of donor egg.*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$15 per PCP office visit $20 per Specialist office visit	$15 per PCP office visit $35 per Specialist office visit (No deductible when a copayment is applied).
• Allergy injections • Allergy Serum	Nothing	Nothing
Not covered: *The following immunotherapy and testing methods are not covered:* *Immunotherapy-* • *Provocative and neutralization therapy for food allergies* • *Sublingual* • *Urine autoinjections* • *Repository emulsion therapy* • *Serial dilution endpoint titration therapy* *Testing-* • *Cytotoxid food testing* • *Leukocyte histamine release*	*All charges*	*All charges*

Allergy care - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Allergy care (cont.)	**High Option**	**Standard Option**
• *Provocative testing for food or food additive allergies* • *Sublingual (antigens prepared for sublingual administration)* • *Serial dilution endpoint titration (SDET)/Skin endpoint titration (SET)* • *Nasal challenge testing* • *Conjunctival challenge testing (ophthalmic mucous membrane testing)* • *Rebuck skin window testing* • *Elisa/Act qualitative antibody testing and IgG ELISA, indirect method*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 42. We cover injectable chemotherapy under the medical benefit and oral chemotherapy under the prescription drug benefit.	Nothing	Nothing
• Respiratory and inhalation therapy	$20 per Specialist office visit for evaluation and re-evaluations	$35 Specialist office visit for each therapy visit (including evaluations and re-evaluations). (No deductible when a copayment is applied)
• Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing You must obtain prior authorization for these services.	Nothing You must obtain prior authorization for these services.
• Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit and requires preauthorization from the Pharmacy Benefit Manger (PBM).	Applicable prescription drug copayment	Applicable prescription drug copayment

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Treatment therapies (cont.)	**High Option**	**Standard Option**
Note: – We only cover GHT when we preauthorize the treatment. You must ask your plan provider to submit information that establishes that the GHT is medically necessary. Your plan provider must ask the PBM to authorize GHT before you begin treatment; otherwise, GHT services will be covered from the date approval is issued by the PBM. If you do not ask or if the PBM determines GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	Applicable prescription drug copayment	Applicable prescription drug copayment
Physical and occupational therapies	**High Option**	**Standard Option**
• Physical therapy, occupational therapy, orthoptic therapy, urinary incontinence therapy and cardiac therapy- - qualified physical therapists; occupational therapists; orthoptic therapists; urinary incontinence therapists; and cardiac therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. The specialist copay will be applicable for rehabilitation therapy services rendered in a home setting.	$20 per Specialist office visit for evaluations and re-evaluations You must obtain prior authorization for these services	$35 Specialist office visit for all therapy visits (including evaluations and re-evaluations) (No deductible when a copayment is applied) You must obtain prior authorization for these services
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Rehabilitative therapy services, including spinal manipulation therapy, for chronic problems or routine maintenance for chronic conditions*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Speech therapy performed by qualified speech therapists Note: The specialist copay will be applicable for rehabilitation therapy services rendered in a home setting.	$20 per Specialist office visit for evaluations and re-evaluations You must obtain prior authorization for these services	$35 per Specialist office visit for all therapy visits (including evaluations and re-evaluations) (No deductible when a copayment is applied) You must obtain prior authorization for these services

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing screening for diagnostic purposes when related to a medical diagnosis when provided or referred by your Plan physician • Hearing testing for children through age 17, (see *Preventive care, children)*	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit $20 per Specialist office visit if you must have an office visit to receive these services	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit $35 per Specialist office visit if you must have an office visit to receive these services (No deductible when a copayment is applied)
Hearing aid evaluation test (one test per ear within a period of 36 months)	$20 per specialist office visit	$35 per specialist office visit (No deductible when a copayment is applied)
Hearing Aids are limited to an $800 maximum for one hearing aid per ear purchased within a period of 36 months.	Any remaining amount above the Plan maximum of $800 per hearing aid per ear per 36 months.	Any remaining amount above the Plan maximum of $800 per hearing aid per ear per 36 months.
Not covered: • *Services or supplies provided in connection with repairs or servicing of the hearing aids or for the replacement parts*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Vision screening to determine the need for vision correction for children through age 17 (see Preventive care, children) • Vision screening for diagnostic purposes when related to a medical diagnosis when provided or referred by your Plan physician	Nothing if you receive these services during an associated office visit of if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit $20 per Specialist office visit if you must have an office visit to receive these services	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit $35 per Specialist office visit if you must have an office visit to receive these services (No deductible when a copayment is applied)
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	Nothing

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Vision services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
Not covered: • *Eye glassesor contact lenses and after age 17, examinations for them* • *Eye glasses or contact lenses or the fitting of contact lenses, except one pair of standard eyeglasses or contact lenses following cataract surgery when the physician does not prescribe an intraocular lens.* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and Prosthetic devices for information on podiatric shoe inserts.	$15 per PCP office visit $20 per Specialist office visit	$15 per PCP office visit $35 per Specialist office visit (No deductible when a copayment is applied)
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• 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, 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	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics when not an integral part of a leg brace or necessary for the management of severe diabetic foot disease or it complications* • *Heel pads and heel cups* • *Lumbosacral supports* • *Cost of penile implanted devices*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Canes; • Walkers; • Ostomy supplies; and • Insulin pumps, and diabetic orthotics Note: Diabetic related supplies and blood glucose monitors are covered under Prescription drug benefit.	Nothing . $15 per PCP office visit $20 per Specialist office visit for evaluation or fitting You must obtain prior authorization for purchases or repairs greater than $300	Nothing. $15 per PCP office visit $35 per Specialist office visit for evaluation or fitting (No deductible when a copayment is applied) You must obtain prior authorization for purchases or repairs greater than $300
Hair prostheses are limited to $300 per member per lifetime.	Any remaining amount above the Plan maximum of $300 per member per lifetime.	Any remaining amount above the Plan maximum of $300 per member per lifetime.
Oral appliances for sleep apnea are limited to a maximum Plan payment of $340 per appliance.	Any remaining amount above the Plan maximum of $340 per appliance.	Any remaining amount above the Plan maximum of $340 per appliance.
Not covered: • *Durable medical equipment requested specifically for travel purposes, recreational or athletic activities or when the intended use is primarily outside the home.* • *Replacement of lost or stolen items within the expected useful life of the originally purchased durable medical equipment.* • *Items that are for convenience and not primarily medical in nature.* • *Supplies determined by KHP Central to be not medically necessary.*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), or licensed practical nurse (L.P.N.). • Services include oxygen therapy, intravenous therapy and medications.	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Homemaker services and other non-medical home health care services* • *Private nursing care*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• You can receive chiropractic services or manipulation therapy services for acute care when the services are associated with an accident or injury and preauthorized by KHP Central. You must seek treatment within one (1) 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, and initial consultation or office visit, certain types of manipulation therapy and physical therapy. Note: Manipulation therapy performed by your primary care physician (PCP) accumulates toward your chiropractic/manipulation therapy benefit limit.	$15 per PCP office visit $20 per Specialist office visit You must obtain prior authorization for these services	$15 per PCP office visit $35 per Specialist office visit (No deductible when a copayment is applied) You must obtain prior authorization for these services
Not covered: • *Chronic problems and routine chiropractic maintenance services*	*All Charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
No benefit	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Educational classes and programs	**High Option**	**Standard Option**
• **Diabetes Education Classes**. You are eligible to attend self-management education and training. These classes are designed to provide you with the skills necessary to manage diabetes. We will provide coverage for attendance to a standard program that is recognized by the American Diabetes Association (ADA). The classes are available to all our members with a diagnosis of diabetes. If you are interested in a diabetic education class, please discuss with your PCP.	Nothing	Nothing
• **Nicotine Cessation Program**. We offer a nicotine cessation program in partnership with the American Cancer Society and the Pennsylvania Department of Health's PA Quit Line. The nicotine cessation program is designed to support members when they are ready to stop smoking or to stop using tobacco products (such as snuff, chew, etc.). This program provides members with educational information on the benefits of nicotine cessation through delivery of telephone counseling sessions focused on a member's level or readiness to change. Educational mailings are offered to support and enhance a member's knowledge on specific techniques to facilitate nicotine cessation. Additionally, this program includes nicotine replacement therapy in combination with the telephonic counseling sessions. This program is offered to members twice per lifetime.	Nothing	Nothing
• **Maternity Management**. Precious Baby Prints® is a voluntary maternity management program designed to support expectant mothers who experience both complicated and uncomplicated pregnancies. Program participation extends throughout pregnancy, delivery and postpartum care. The program provides educational information, teaching, and personalized support to pregnant members. - The assessment phase of the program includes a questionnaire that helps identify members who may be at risk for pregnancy-related complications or who may be experiencing complications. Members identified as being potentially at high risk for complications are assigned a Maternity Care Manager (R.N.) for more intensive personalized services.	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
- Program activities for low risk members are designed to supplement the advice and treatment provided by the member's Obstetric provider and physicians. The program is tailored to each member's individual health and educational needs and provides credible educational materials related to pregnancy, general health issues, childcare and parenting skills.	Nothing	Nothing
Nutritional Counseling for Obese Children. Children through age 18 who are diagnosed with obesity are eligible for nutritional counseling. Two sessions of nutritional counseling are provided per child per benefit period. Eligible providers of this service are limited to Licensed Dietitian-Nutritionists.	$20 per Specialist office visit	$35 per Specialist office visit (No deductible when a copayment is applied)
Not covered: education/training and nutritional counseling, when performed by other than your primary care physician (PCP), except for the diagnosis of diabetes, and nutritional counseling for obese children.	*All charges*	*All charges*
Our Disease Management Programs are collaborative programs that assess the health needs of an individual with a chronic condition and provides education, counseling and on-demand information designed to increase a member's self-management of his/her disease. Current programs available to you are listed below. Please contact our Customer Service Department at the number listed on the front of your ID card for additional information regarding our Disease Management Programs. • **Asthma.** We have partnered with a disease management vendor to provide disease management for our adult members with asthma. Telephonic education and support by a health professional is provided along with educational mailings for those members who participate in the program. Members can learn about diet, exercise, behavior modifications and medications. We also deliver disease management services to our pediatric population. The goal of this asthma program is to improve the quality of life for our members with asthma expanding the knowledge base of both child and family through educational interactions with a disease manager to assist them better self-manage their condition.	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• **Coronary Artery Disease (CAD).** We have partnered with a disease management vendor to provide disease management for our adult members with coronary artery disease (CAD). Telephonic education and support by a health professional is provided along with educational mailings for those members who participate in the program. Members can learn about diet, exercise, behavior modification and medications. • **Congestive Heart Failure (CHF).** We have partnered with a disease management vendor to provide disease management for our adult members with congestive heart failure (CHF). Telephonic education and support by a health professional is provided along with educational mailings for those members who participate in the program. Members can learn about diet, exercise, behavior modifications and medications. • **Diabetes.** We have partnered with a disease management vendor to provide disease management for our adult members with diabetes. Telephonic education and support by a health professional is provided along with educational mailings for those members who participate in the program. Members can learn about diet, exercise, behavior modifications and medications. We also deliver disease management services to our pediatric population. The key objective of this program is to focus on preventing the development or progression of diabetes-related complications. Members diagnosed with diabetes and identified as high or moderate risk are encouraged to engage in our voluntary program where members receive telephonic assessments, interventions and monitoring of their progress through interaction with our disease manager. This program educates members and their families about improved self-care, lifestyle, medications and personal empowerment. All members identified for the diabetes program receive periodic mailings of educational information to support their on-going educational process. • **Low Back Pain.** Our low back pain management program serves to improve the quality of life for members with chronic back pain and to provide educational materials to members on the self-management of their symptoms. The program has many areas of concentration including back care education, exercise, pain management and measures to deal with the anxiety and/or depression that may accompany back pain.	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• **Depression**. We offer a depression program designed to improve a member's ability to recognize signs and symptoms of depression and to seek and receive appropriate treatment. The program includes member education focused on early detection, appropriate treatment interventions, and measures to improve the member's functional ability. We currently offer this program to members in association with pregnancy-related depression and to members currently enrolled in one of our other disease management programs.	Nothing	Nothing

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

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.
- The calendar year deductible is: $250 per person ($750 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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 FOR 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.
- **YOUR PHYSICIAN MUST COMPLETE A REFERRAL NOTIFICATION FOR SOME SERVICES**. Please refer to the referral information shown in Section 3 to be sure which services require referral notification (see page 15).

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • 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*) • Surgical treatment of morbid obesity (bariatric surgery) - Patients must be morbidly obese; which is defined as a body mass index (BMI) greater than or equal to 40, **or** have a BMI greater than or equal to 35 with at least one of the following problems.	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Incapacitating skeletal derangement or degenerative changes with documentation of incapacity in performing basic activities of daily living (BADL); **or** • Obstructive sleep apnea for which CPAP has been recommended or obesity hypoventilation syndrome documented with appropriate studies of respiratory function including blood gases, sleep studies, etc.; **or** • Documented, associated diseases requiring prescription medical therapy including diabetes, medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management), dyslipidemia that despite appropriate medical therapy has not reached recommended levels, or coronary artery disease; **AND** - Does not have a untreated, correctable endocrine disorder specifically related to obesity; **AND** - Patient is at least 18 years of age or fully grown (with documentation of closure of epiphyseal plates). • 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 You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Neonatal circumcisions* • *Any services determined to be not medically necessary by KHP Central*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can be reasonably 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; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - 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*) 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.	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation* • *Any services determined to be not medically necessary by KHP Central*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral and maxillofacial surgical procedures include but are not limited to: • Surgical correction of congenital defects, such as cleft lip and cleft plate; • 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;	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
• 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.	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), including any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to Other services in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description. • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Single, double or lobar lung • Small bowel • Solitary Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - Small intestine - Small intestine with the liver	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Small intestine with multiple organs, such as the liver, stomach, and pancreas	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myleogenous leukemia - Hemoglobinopathy (i.e. Fanconi's, Thalessemia major) - Myelodyplasia/Myelodyplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis • Autologous transplant for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - De-novo myeloma	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services
Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) Advanced neuroblastoma	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Infantile malignant osteoporosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloprolifertive disorders - Sickle cell anemia - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Pineoblastoma	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services
Mini-Transplants (non-myeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services
Tandem transplants (for covered transplants): Subject to medical necessity	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for:	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• KHP Central determines the medical necessity and appropriateness of transplants for clinical trials on an individual basis. To be considered, the trial must meet specific criteria established by KHP Central and is not based on diagnosis alone.	Nothing You must obtain prior authorization for these services	Nothing You must obtain prior authorization for these services
Blue Distinction Centers for Transplant (BDCT): Blue Distinction Centers for Transplant are a cooperative effort of the Blue Cross and/or Blue Shield Plans, the Blue Cross and Blue Shield Association and participating medical institutions to provide patients who need transplants with access to leading transplant centers through a coordinated, streamlined program of transplant management. When a transplant is performed at a BDCT facility designated for that transplant type, benefits are paid for travel, lodging, and meal expenses for the member and one support companion. This benefit is limited to $10,000 per transplant episode.	Any remaining amount above the Plan maximum of $10,000 per transplant episode. You must obtain prior authorization for these services.	Any remaining amount above the Plan maximum of $10,000 per transplant episode. You must obtain prior authorization for these services.
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Any treatment, procedure, facility, equipment, drug, drug application, drug usage device or supply, which we determine is not accepted as standard medical treatment for the condition being treated. We rely on available credible data and the advice of the medical community, including but not limited to medical consultants, medical journals and/or government regulations, to guide us in our decisions.* • *Any such item 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 of services were rendered or requested.* • *Items such as, but not limited to, alcohol, tobacco, car rental, entertainment, phone calls, personal care items, and expenses for persons other than the member and his/her companion under the BDTC travel benefit.*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	Nothing
Not Covered: • *Acupuncture*	*All charges*	*All charges*

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

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 and you must be hospitalized in a Plan facility.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible is: $250 per person ($750 per family) under the Standard Option.
- 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 PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification (see page 13).

Benefit Description	You pay	
Note: The calendar year deductible applies only when we say below: "(calendar year deductible applies)." Standard Option only		
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$200 per admission You must obtain prior authorization for these services	$100 per day up to a maximum of $500 per admission You must obtain prior authorization for these services
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Administration of blood or blood products • Diagnostic laboratory tests and X-rays • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen	Nothing	Nothing
• Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary* • *Take-home items* • *Whole blood, blood plasma or blood components*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing You must obtain prior authorization for these services	$100 outpatient facility surgery copayment You must obtain prior authorization for these services
Not covered: Whole blood and blood plasma and blood components	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
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 appropriated by your Plan physician and approved by us. We cover all necessary services including but not limited to: • Room, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan physician	$200 per admission You must obtain prior authorization for these services	$100 per day up to a maximum of $500 per admission You must obtain prior authorization for these services

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits (cont.)	**High Option**	**Standard Option**
Not covered; Custodial care, domicillary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
You are eligible for supportive and palliative care up to a maximum of $50,000 per member per lifetime when you become terminally ill. These services are generally 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. Respite care is limited to 10 days in a facility provider or 240 hours of in-home respite care per member per lifetime.	Nothing	Nothing (calendar year deductible applies)
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
You can receive medically necessary ambulance services when required in connection with emergency services or when your Plan provider orders and we preauthorize services in connection with non-emergent care.	Nothing You must obtain prior authorization for non-emergency services	Nothing (calendar year deductible applies to non-emergency services) You must obtain prior authorization for non-emergency services
Not covered: ambulance services when not medically necessary, or non-emergent service not authorized by us.	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

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.
- The calendar year deductible is: $250 per person ($750 per family) under the Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply
- 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.

What is a medical emergency?

An emergency service is defined as any health care service provided to a member 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 her unborn child in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part

Transportation and related emergency services provided by a licensed ambulance service shall also be considered emergency services if the condition meets the definition of emergency services as defined above.

Some examples of emergencies are: heart attack, stroke, poisoning, loss of consciousness or respiration, convulsions, and acute psychiatric symptoms that could result in physical harm to you or others if not treated immediately.

What to do in case of emergency:

In an emergency situation, your first concern is to obtain necessary medical treatment. If the circumstances prevent you from contacting your PCP, seek emergency services from the nearest appropriate facility. **Emergency services do not require preauthorization or a referral from your PCP**. Contact your PCP after receiving emergency services but before receiving follow-up care. Please note that your PCP must coordinate follow-up care for it to be covered by us. Your PCP's phone number is on the front of your ID card. You can also get this phone number by calling our Customer Service Department at 1-866-987-2142 (TDD 1-800-669-7075).

If you receive care from an emergency services provider in a situation which you believe to be an emergency, without obtaining a referral from the PCP, you may be requested to provide information about the occurrence. We will then review the facts of the situation and the nature of the services provided. If we determine the services constitute emergency services, as defined above, the emergency services will be covered. In the event that the services do not constitute emergency services as defined above, the cost of the services will NOT be covered.

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, and swollen glands.

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

Urgent care outside our service area: When you are traveling outside of the KHP Central service area and need health care services, several guidelines apply. You should utilize the BlueCard Urgent Care Benefit described below or contact your PCP.

You and your eligible dependents may receive emergency services while traveling out of the KHP Central service area, wherever you may be. See the emergency services information listed above.

KHP Central does not pay for routine (such as physicals) or other non-urgent care provided outside of the service area. You should schedule such care while in the area through regular appointments with your PCP. If you are going out of the area for vacation or a business trip, for example, contact your PCP and schedule routine care before you leave.

- **BlueCard Urgent Care Benefit:** For urgent medical situations (non-emergency services that need attention within twenty-four (24) hours) when you are traveling out of the service area, you may be able to receive treatment by using KHP Central's urgent care benefit. KHP Central participates in BlueCard, a national network of BlueCross and/or BlueShield providers that have agreed to provide urgent care for BlueCross and/or BlueShield members. By calling 1-800-810-2583, a BlueCard representative will provide you with a list of three (3) providers in the area who can meet your medical needs. You can also obtain a list of participating providers via the Internet at www.bcbs.com. If you experience an emergency situation (at your home or away), go to the closest medical facility to get the care you need. Contact your PCP to inform him/her of your visit. If necessary, you PCP will coordinate services under BlueCard Follow-Up Service (refer to the next paragraph). 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.
- **BlueCard Follow-Up Service:** When follow-up care is required after receiving care under the BlueCard Urgent Care Benefit, your PCP must be contacted prior to receiving these follow-up services. Your PCP will coordinate and authorize all services he/she deems necessary for you to receive prior to returning to the service area. If you do not contact your PCP before receiving follow-up services, the services will not be covered by KHP Central. If you obtain care through your BlueCard Urgent Care Benefit, you should have not to pay for your services other than any applicable copayment or coinsurance. However, if you obtain care from a provider that does not participated with the local BlueCard Plan, you may be required to pay in full for the services your receive. The back of your ID card lists a toll-free number which providers can call with questions about your coverage. If you pay for the services, please send us a copy of the bill which should include itemized charges, the procedure codes, the date of service, description of services provided, and the diagnosis. You will be reimbursed for emergency services or otherwise properly referred and preauthorized benefits. Send these bills to:

Capital BlueCross P.O. Box 779503 Harrisburg, PA 17177-9503

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• 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	$15 per PCP office visit during normal office hours $25 per PCP office visit after hours usually scheduled for appointments (No deductible when a copayment is applied)
• 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.	$75 per visit $15 if you are referred by your PCP and the service could have been provided in the PCP's office. (No Deductible)
Emergency care as an outpatient 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.	$75 per visit $15 if you are referred by your PCP and the service could have been provided in the PCP's office. (No deductible) Copayment waived if we authorize your admittance. However, if you are admitted, you will pay a $100 per day inpatient copayment up to a maximum of $500 per admission.
Not covered when not preauthorized by us: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services	Same as for Emergency within our service area.	Same as for Emergency within our service area.
Not covered when not preauthorized by us: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance	**High Option**	**Standard Option**
Professional ambulance service when medically appropriate. These include, but are not limited to: • Air ambulance • Basic life support • Advanced life support • Invalid coach service Note: See 5(c) for non-emergency service	Nothing	Nothing (No deductible for emergency ambulance service)
Not covered: ambulance services when not medically necessary, or non-emergent services not preauthorized by us.	*All charges*	*All charges*

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

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.

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.
- The calendar year deductible is $250 per person ($750 per family) under the Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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 FOR THESE SERVICES (EXCEPT FOR EMERGENCY SERVICES).** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply. Standard Option only		
Mental health and substance abuse benefits	**High Option**	**Standard Option**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers	$20 per Specialist office visit	$35 per Specialist office visit
• Medication management	You must contact KHP Central's behavioral health vendor at 1-800-216-9748 prior to obtaining services	You must contact KHP Central's behavorial health vendor at 1-800-216-9748 prior to obtaining services
Diagnostic tests	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $20 per Specialist office visit, if you must have an office visit to receive these services.	Nothing if you receive these services during an associated office visit or if we authorize the service and your provider refers you. Otherwise, $15 per PCP office visit or $35 per Specialist office visit, if you must have an office visit to receive these services.

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Mental health and substance abuse benefits (cont.)	**High Option**	**Standard Option**
		(No deductible when a copayment is applied)
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$200 copayment per inpatient admission You must obtain prior authorization for these services	$100 per day inpatient copayment up to a maximum of $500 per admission (No deductible when a copayment is applied) You must obtain prior authorization for these services
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*	*All charges*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

Your mental health and substance abuse treatment, which is also referred to as behavioral health services, is provided by KHP Central's behavioral health vendor. You are eligible for a full range of services including inpatient care, partial hospitalization programs, intensive outpatient treatment, outpatient individual/family counseling and other levels of care appropriate to individual needs.

Contacting Your Mental Health Provider.

Prior to accessing behavioral health services that do not qualify as emergency services, you must contact KHP Central's behavioral health vendor at 1-800-216-9748 (TDD 1-877-342-6815). For outpatient non-emergency services to be covered, the services must be received from a network provider and must have a prior notification by the behavioral health vendor. A list of all participating mental health and substance abuse providers can be found in our provider directory and on KHP Central's website at www.capbluecross.com.

If you are faced with a crisis, contact KHP Central's behavioral health vendor at 1-800-216-9748. Care Managers and network providers are available twenty-four (24) hours a day, seven (7) days a week, to offer assistance and coordinate care.

KHP Central's behavioral health vendor also offers translator services to its non-English speaking members. To access this service, simply call the behavioral health vendor.

Inpatient Services-Mental Health or Substance Abuse. If a need for inpatient care is identified, the inpatient stay must be preauthorized by KHP Central's behavioral health vendor.

Emergency Services. Emergency services do not have to preauthorized, but you or your family should contact your PCP or KHP Central's behavioral health vendor after receiving these services but before receiving follow-up care. Refer to section 5(d), *Emergency services/accidents*, for further information.

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

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- The calendar year deductible is: $50 per person ($150 per family) under the Standard Option. The calendar year deductible applies to all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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.

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 and who is licensed and legally entitled to prescribe prescription drugs must write the prescription order.

Where you can obtain them? You have the option of going to any retail pharmacy or using the mail service pharmacy. Your costs are generally less when you obtain prescription drugs from a participating pharmacy. You must obtain specialty prescription drugs from the specialty prescription drug vendor.

At a participating retail pharmacy, simply show your KHP Central ID card when you present your prescription order and you pay the cost share specified by your prescription drug benefit (please refer to the "These are the dispensing limitations' information below).

At a non-participating pharmacy, you must pay the non-participating pharmacy's charge for such prescription drugs. You may then submit a designated claim form for reimbursement of covered drugs. You will be reimbursed the amount, less any cost share specified by your prescription drug benefit (please refer to the 'These are the dispensing limitations' information below), that we would have paid if you had used a participating pharmacy.

Mail service dispensing is provided through a 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. A mail service pharmacy packet can be obtained by calling KHP Central's Customer Service Department at 1-866-987-2142 (TDD 1-800-669-7075). Or, you can order your prescription drugs by visiting KHP Central's Web site at www.capbluecross.com. This will provide you with a link to the PBM's online pharmacy. Certain prescription drugs will not be available for mail service dispensing due to safety and quality reasons.

Certain specialty prescription drugs must be obtained through our specialty prescription drug vendor. The specialty pharmacy usually ships your medication overnight via UPS or Federal Express within twenty-four (24) hours of receiving your prescription order. Prior to delivery, a representative from the specialty pharmacy will call you to verify your delivery information and set up payment arrangements for your cost share.

To obtain the most current list of specialty prescription drugs, visit KHP Central's Web site at www.capbluecross.com or call the specialty pharmacy at 1-877-595-3707.

We use a formulary. We use a drug formulary to help manage your prescription drug benefit. The drug formulary is a continually updated list of prescription drugs which represent the current clinical judgment of physicians and other experts in the treatment of disease and prevention of health. Our Pharmacy and Therapeutics Committee developed the drug formulary and meets regularly 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 prescribers. Therefore, the drug formulary is subject to change throughout the year. Updates to the drug formulary will be reported in the Member newsletter, on KHP Central's website at www.capbluecross.com or other official notice of change.

Under the drug formulary, prescription 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 our drug formulary, visit KHP Central's Web site at www.capbluecross.com, or call KHP Central's Customer Service Department at 1-866-987-2142 (TDD 1-800-669-7075).

These are the dispensing limitations. We encourage the use of generic drugs through the Mandatory Generic Substitution Program. When a generic drug is dispensed, you are responsible for paying only the applicable generic drug copayment or coinsurance. When a brand drug is dispensed that has a generic equivalent, you are responsible for paying the applicable brand drug copayment or coinsurance plus the difference in price between the brand drug and its generic drug equivalent, up to the original cost of the brand drug. When a brand drug is dispensed that has no generic drug equivalent, you are responsible for paying only the applicable drug copayment or coinsurance.

Up to a thirty (30) day supply of drugs can be obtained at a participating retail pharmacy or through the specialty prescription drug vendor by paying your applicable copayment or coinsurance. You can request that your prescription order 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 order. You will receive instructions with each order explaining how to reorder your prescription drugs. You can request that your mail service prescription order be refilled after approximately sixty percent (60%) of the quantity has been used. If you are in the military and called to active duty to an emergency, please contact us if you need assistance in filling a prescription before your departure.

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

Why use generic drugs? All drugs have a chemical name. A generic drug is one that is identified by its official chemical name rather than the advertised brand name. Generic drugs available in the U.S. have the same active chemical ingredients and have been deemed by the Food and Drug Administration (FDA) to produce the same effect on the body as their brand-name counterparts. Not every brand has a generic drug counterpart. On average, most generic drugs are about half the price of the brand drug because there is much less money spent advertising, promoting, marketing, researching and developing the generic version of the drug. Therefore, you can help control your health care costs by obtaining generic drugs (when available) without compromising the quality of your treatment. This is your decision. Ask your prescriber and pharmacist if a generic drug equivalent is available for all of your prescriptions.

Some drugs require prior authorization. We have a prior-authorization process in place through the PBM to review requests for certain prescription drugs and compare them with clinical guidelines for appropriateness. The PBM's clinical team will generally authorize a prescription drug for up to a twelve (12) month period. Delays may occur in receiving these prescription drugs to allow for clinical review of prescriber submitted information.

Another form of prior-authorization that we use is enhanced prior-authorization (step-therapy). Enhanced prior-authorization (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 prescriber believes that it is medically necessary for a second-line drug to be used without trial of a first-line drug, the prescriber can request consideration through the PBM.

Questions regarding which prescription drugs require prior-authorization may be directed to the PBM at 1-800-585-5794 or KHP Central at 1-866-987-2142 (TDD 1-800-669-7075). Additionally a list of prescription drugs requiring prior-authorization is available on KHP Central's Web site at www.capbluecross.com. Updates to the prior-authorization list will be reported to you in KHP Central's newsletter or other official notice of change.

If your drug requires prior-authorization, your prescriber may either call the PBM at 1-800-417-8164 or fax a completed Prescription Prior-Authorization Form, along with any supporting documentation, to the PBM at 1-800-357-9577. You or your prescriber can download a Prescription Prior-Authorization Form from our Web site at www.capbluecross.com.

If you are given a prescription order for a prescription drug that requires prior-authorization and try to obtain the prescription drug at the pharmacy without having obtained prior-authorization, your prescriber will receive a phone call from the pharmacist and/or the PBM to obtain the information. Therefore, it will be more convenient for you and your prescriber to provide this information in advance. If necessary, the PBM reviewers will contact your prescriber 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 the PBM receives all of the applicable information. The requestor (the prescriber and/or dispensing pharmacy) will be initially notified via phone or fax of the decision within two (2) working days from the date the PBM received all applicable information.

If the prescription drug 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 prescription drug with each subsequent one-year authorization effective with a new prior-authorization approval.

If the prescription drug is denied, the denial decision, including appeal information, will also be confirmed and communicated in writing to you, with a copy forwarded to the prescriber and to us within two (2) working days of making the decision. You and/or your prescriber, **with your written consent**, may file a grievance. See page 68 of this brochure for information on filing a grievance with us.

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply. Standard Option only		
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program. Specialty medications are available through our specialty pharmacy vendor. • Drugs on our drug formulary • Drugs and medicines that by Federal law of the United States require a physician'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 blood glucose monitors • Compounded preparations containing at least one prescription drug • Oral Chemotherapy • Prescription vitamins (Prenatal or Non-Prenatal) • Disposable needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Drugs for Growth Hormone Therapy • Specialty medications (To obtain the most current list of specialty prescription drugs, visit KHP Central's Web site at www.capbluecross.com or call the specialty pharmacy at 1-877-595-3707)	At a participating retail pharmacy: • A $10 (generic)/ $25 (preferred brand)/ $40 (non-preferred brand) copayment for up to a **30-day** supply per prescription unit or refill; From the mail service pharmacy: • A $20 (generic)/ $50 (preferred brand)/ $80 (non-preferred brand) copayment for up to a **90-day** supply per prescription unit or refill; From the specialty pharmacy: • A $10 (generic)/ $25 (preferred brand)/ $40 (non-preferred) copayment for up to a **30-day** supply per prescription unit or refill.	Deductible: $50 per person ($150 per family) At a participating retail pharmacy: • A $5 (generic)/ $35 (preferred brand)/ $60 (non-preferred brand) copayment for up to a **30-day** supply per prescription unit or refill; From the mail service pharmacy: • A $10 (generic)/ $70 (preferred brand)/ $120 (non-preferred brand) copayment for up to a **90-day** supply per prescription unit or refill; From the specialty pharmacy: • A $5 (generic)/ $35 (preferred brand)/ $60 (non-preferred brand) copayment for up to a **30-day** supply per prescription unit or refill.

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
	• 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.	• 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 drug. • If a non-preferred brand drug is dispensed that has a generic equivalent, you will be responsible for paying the non-preferred drug copayment plus the difference in price between the non-preferred drug and the generic equivalent, up to the original cost of the non-preferred brand drug.
We cover the following medications and supplies prescribed by a Plan physician and obtained from a participating pharmacy or through the mail order program. Specialty medications are available through our specialty pharmacy vendor. • Drugs for erectile dysfunction are subject to dose or quantity limitation. Call the Plan for specific limitations • Drugs used to treat infertility. Note: Drugs used to treat infertility are covered as long as infertility is not due, in part or in its entirety, to either party (whether a KHP Central member or not) having undergone a voluntary sterilization procedure and/or reversal of the voluntary sterilization procedure that was not successful.	50% coinsurance	50% coinsurance (calendar year deductible applies)
Not covered: • *Prescription drugs which are not medically necessary as determined by Capital or its designee;* • *Drugs that do not legally require a prescription as determined by Capital, and drugs that have an over-the-counter equivalent;* • *Prescription drugs received in and billed by a hospital, nursing home, home for the aged, convalescent home, home health care agency, or similar institution;*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible (Standard Option only)	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• *Prescription drugs considered by Capital or its designee to be experimental or investigational;* • *Any prescription drugs for illness or injury suffered after the member's effective date of coverage which resulted from an act of war, whether declared or undeclared;* • *Prescription drugs and over-the-counter drugs dispensed during travel by a physician employed by a hotel, cruise line, spa or similiar facility;* • *Prescription drugs utilized primarily to enhance physical or athletic performance or appearance;* • *Prescription drugs utilized to promote hair growth;* • *Prescription drugs utilized for cosmetic purposes;* • *Prescription drugs utilized in connection with non-covered medical services;* • *Any other prescription drugs, service or treatment, except as provided under this coverage;* • *Prescription drugs utilized for weight loss purposes, except for treatment of morbid obesity;** • *Smoking cessation products ** **Note: When smoking cessation 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, these prescription drugs may be obtained at any participating pharmacy or mail service pharmacy at a coinsurance equal to 100% of our cost for the prescription drug. Otherwise, these drugs are considered not covered under your prescription drug benefit.*	*All charges*	*All charges*

Section 5(g). Dental benefits

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
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The calendar year deductible is: $250 per person ($750 per family). The calendar year deductible applies to all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- We cover hospitalization for dental procedures only when a 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.

Benefit Desription	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover dental and oral surgery services (on a limited basis) as a result of an accident. Accidental injury would include unintentional traumatic injury to the jaw or structure contiguous to the jaw, including injury to the teeth, and does not include conditions resulting from dental disease or occurring during the normal chewing process. Only those medically necessary services immediately required in response to the emergency and to stabilize the condition of the member will be covered.	Nothing	Nothing (No deductible)
Dental benefits	**High Option**	**Standard Option**
We have no other dental benefits.		

Section 5(h). Special features

Feature	Description
BlueCard Urgent Care-Out of Area Services	If you are traveling outside the Plan's service area and require urgent care, you need to use the following procedure: • Contact the 24-hour, toll-free provider locator service at 1-800-810-2583 or log on to www.bcbs.com. • You will receive information regarding three available local providers (names, addresses, phone numbers, and directions) who can meet your medical needs. • You will need to select a provider and schedule your own appointment. • At the appointment, you must present your 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. **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.
BlueCard Follow-Up Services -Out of Area Services	When follow-up care is required after receiving care under the BlueCard Urgent Care Benefit, your PCP must be contacted prior to receiving these follow-up services. Your PCP will coordinate and authorize all services he/she deems necessary for you to receive prior to returning to the service area. If you do not contact your PCP before receiving follow-up services, the services will not be covered by KHP Central. If you obtain care through your BlueCard Urgent Care Benefit, you should not have to pay for your services other than any applicable copayment or coinsurance. However, if you obtain care from a provider that does not participate with the local BlueCard Plan, you may be required to pay in full for the services you receive. The back of your ID card lists a toll-free number which providers can call with questions about your coverage. If you pay for the services, please send us a copy of the bill which should include itemized charges, the procedure codes, the date of service, description of services provided, and the diagnosis. You will be reimbursed for emergency services or otherwise properly referred and preauthorized benefits. Send these bills to: Capital BlueCross PO Box 779503 Harrisburg, PA 17177-9503
Out-of-Country Services	BlueCard Worldwide provides Members with access to network emergency and urgent services around the world. Members traveling or residing outside of the United States have access to doctors and hospitals in more than 200 countries. If you are traveling outside the United States, remember to always carry your KHP Central ID card. For situations that require urgent care, call 1-800-810-2583. A medical coordinator, in conjunction with a medical professional, will assist you in locating appropriate care. The BlueCard Worldwide Service Center is staffed with multilingual representatives and is available 24 hours a day, 7 days a week. As soon as reasonably possible after services are rendered, you should contact your PCP to advise him/her of the care you received and/or to authorize follow-up services if needed. Your PCP must notify KHP Central and obtain authorization for these services. Your PCP's telephone number is listed on the front of your ID card. If emergency services are needed, go to the nearest hospital. Call the BlueCard Worldwide Service Center at 1-800-810-2583 or call collect (1-804-673-1177) if admitted.

	To locate providers outside the United States, call BlueCard Worldwide Service Center 1-800-810-2583 24 hours a day, 7 days a week, or go to www.bcbs.com. **KHP Central does not pay for routine care (i.e., physicals) or other non-urgent care provided outside of the service area. You should schedule such care while in the service area through regular appointments with your PCP. If you are going out of the service area for vacation or a business trip, for example, contact your PCP and schedule routine care before you leave.**
Away From Home Care-Guest Membership	If you or a dependent will be out of the area for an extended period, such as a child at an out of area college, you may wish to enroll in our Away From Home Guest Membership program. 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 have through KHP Central. Essentially, you are covered under two plans at the same time, with no additional cost to you. When could a guest membership work for you or your family members? If your away-from-home travel is more extensive than day trips or week vacations, a guest membership may be the answer you are looking for. Members who take extended business trips (three to six months), students at college, or families living apart may all take advantage of the benefit of a guest membership. Not all geographic areas within the United States participate in the Guest Membership Program. Please contact KHP Central's Customer Service Department at 1-866-987-2142 (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. 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. 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.
Nurse Line	You will have easy access to health information whenever you need it, 24 hours a day, 365 days a year. You can speak to a registered nurse or access recorded health information on more than 1,100 health topics. You can access this benefit by calling 1-866-243-1238 and entering PIN number 499.
Healthy Family Fun/Blue365	***Healthy Family Fun/Blue 365*** is a program to encourage our members and their families to get up, get out and get active to help reduce stress and enhance their well-being. Through ***Healthy Family Fun***, you can get some ideas on way to fill an hour or a weekend with enjoyable recreation. For added enjoyment, you can take advantage of some great discounts to local theme parks, sporting events, fitness facilities, and much more by showing your KHP Central ID card at the time of purchase. We also recognize the importance of a healthy mind by including savings on a variety of cultural events. You can also take advantage of nationally available discounts from selected companies through our new online initiative called ***Blue365***. To learn more about our ***Healthy Family Fun/Blue365*** program please visit our website at www.capbluecross.com.
www.capbluecross.com	Make www.capbluecross.com your resource for the information you need to get the most from your health care benefits. We encourage you to explore our Web site to discover the many advantages of being a Keystone Health Plan Central member. Registered members enjoy secure access to personalized services and information. Registration is easy. As a registered member you can:

	• View eligibility and benefits information • Communicate with us through *Capital BlueCross SecureMail* • Update your name and address • Request a duplicate ID card • Check claim status and online Explanations of Benefits • Search for participating doctors, hospitals and pharmacies • Obtain information about our drug formulary • Read about our health management and educational programs • Link to other health care related sites

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. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-866-987-2142 (TDD 1-800-669-7075) or visit their website at www.capbluecross.com.

Discount Health Network

Are you looking for a way to take a more active role in your health? If you live in Central Pennsylvania or the Lehigh Valley, our Discount Health Network may be the answer. The Discount Health Network provides you with easy access to health education resources and programs at a lower cost.

With our searchable vendor database, you can locate classes on a variety of topics ranging from smoking cessation to prenatal care, chronic illnesses, nutrition and more. In some localities, you have the opportunity to joint fitness clubs or weight loss programs at a discount simply by showing your KHP Central ID card.

This information is available on our Web site at www.capbluecross.com.

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. There may be other exclusions and limitations listed in Section 5 of this brochure. **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.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- 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 (see specifics regarding transplants);
- 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, supplies, or devices related to sexual dysfuction, both male and female;
- 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;
- Service 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;
- 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;
- Enteral nutrition, except when it is the sole source of nutrition;
- Travel expenses incurred in conjunction with benefits, unless specifically identified as a benefit elsewhere in this brochure; or
- Clinical cancer trial cost (i.e., drugs under investigation; patient travel expense; data collection and analysis services), except for costs directly associated with medical care and complications, related to an approved trial, which would normally be covered under standard patient therapy.

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, coinsurance, or deductible.

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. For claims questions and assistance, call us at 1-866-987-2142 (TDD 1-800-669-7075). 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 BlueCross and BlueShield 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 received 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: Capital BlueCross, P.O. Box 779503, Harrisburg, PA 17177-9503 or via fax at 717-703-8494.

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 1-866-987-2142 (TDD 1-800-669-7075) and we will help you. You must request any reimbursement within 12 months of the date of service.

Submit your claims to: Express Scripts, Inc., P.O. Box 66583, St. Louis, MO 63166-6583, Attention: Claims Department.

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 benefits for 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 required by Section 3.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Keystone Health Plan Central, FEP Denial Reconsideration Committee, P.O. Box 779869, Harrisburg, PA 17177-9869; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

	Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
5	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, 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 • We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at1-866-987-2142 (TDD 1-800-669-7075) and we will expedite our review; or • 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 202-606-0737 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 has coverage under any other health plan or has 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; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov , or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **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 more 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 or 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.

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.

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare Plan – You will probably not need 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. To find out if you need to do something to file your claim, call us at 1-866-987-2142 (TDD 1-800-669-7075) or see our Web site at www.capbluecross.com.

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

- **Medicare Advantage (Part C)**

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 and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, 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 enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

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.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
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 **(for 30 month coordination period)**		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) 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.

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 TRICARE OR CHAMPVA.

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.

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.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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 26.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 20.

Cost-Sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

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 designated mainly to help the patient with daily living activities. Custodial care that lasts 90 days or more is sometimes known as Long Term Care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 20.

Experimental or investigational service

A service or supply, including, but not limited to, a drug, treatment, device, or procedure is considered experimental or investigational if any of the following criteria are met:

- It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and final approval is not granted at the time of its use or proposed use;
- It is the subject of a current investigational new drug or new device application on file with the FDA;
- The predominant opinion among experts as expressed in medical literature is that usage should be largely confined to research settings;
- The predominant opinion among experts as expressed in medical literature is that further research is needed in order to define safety, toxicity, effectiveness or compared with other approved alternatives; or
- It is not investigational in itself, but would not be medically necessary except for its use with a drug, device, treatment or procedure that is investigational or experimental.

Group health coverage

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

Medical necessity

- Services or supplies that a physician exercising prudent clinical judgement would provide to a Plan Member for the diagnosis and/or direct care and treatment of the Plan Member's medical condition, disease, illness, or injury that are necessary;
- In accordance with generally accepted standards of good medical practice;
- Clinically appropriate for the Plan Member's condition, disease, illness or injury;
- Not primarily for the convenience of the Plan Member and/or Plan Member's family, physician, or other health care provider, and
- Not more costly than alternative services or supplies at least as likely to produce equivalent results for the Plan Member's condition, disease, illness or injury.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

	For professional providers, the plan allowance is the lesser of the provider's billed charge or the amount reflected in our fee schedule, unless otherwise specified in this brochure
	For facility providers, the plan allowance is the negotiated amount agreed to by the provider and KHP Central, unless otherwise specified in this brochure
Us/We	Us and 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.

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/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* 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 family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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 Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot 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 2009 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 2008 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement by not beyond the 60th day after the end of the 31 day temporary extension.

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

Upon divorce

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. However, you may be eligible for your own FEHB coverage under either 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 Benefits 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 Web site, 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site 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. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll**.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA) (formerly known as the Dependent Care FSA)** – Reimburses you for eligible dependent care expenses for your child(ren) under age 13 or for dependents unable to care for themselves that allow you (and your spouse if married) to work, look for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.
Dental Insurance	Dental plans provide a comprehensive range of services, including the following: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crown, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 24-month waiting period.
Vision Insurance	Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888- 3337 (TTY number, 1-877-889-5680).

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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 the High Option of Keystone Health Plan Central - 2009

- **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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $20 specialist	20
High-tech imaging	$50 per visit	21
Services provided by a hospital:		
• Inpatient	$200 copayment per admission	44
• Outpatient	Nothing	45
Emergency benefits:		
• In-area	$50 copayment per emergency room visit	49
• Out-of-area	$50 copayment per emergency room visit	49
Mental health and substance abuse treatment:	Regular cost sharing	51
Prescription drugs:		54
• Participating Retail pharmacy	$10/$25/$40 copayment for up to a **30-day** supply	56
• Mail order	$20/$50/$80 copayment for up to a **90-day** supply	56
• Specialty pharmacy	$10/$25/$40 copayment for up to a **30-day** supply	56
Dental care: We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury	No benefit.	59
Vision care:	No benefit.	29
Special features: BlueCard Urgent Care-Out of Area Services; BlueCard Follow-Up Services-Out of Area Services; Out-of-Country Services; Away From Home Care-Guest Membership; Nurse Line; Healthy Family Fun/Blue365; and; and www.capbluecross.com.		60
Protection against catastrophic costs (out-of-pocket maximum)**:**	We do not have an out of pocket maximum.	80

Summary of benefits for the Standard Option of Keystone Health Plan Central - 2009

- **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.
- Under the standard option benefit, when there is no copayment applied to a service the deductible will apply ($250 per individual and $750 per family).

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $35 specialist	20
High-tech Imaging	$50 per visit	21
Services provided by a hospital:		
• Inpatient	$100 copayment per day up to a maximum of $500 per admission	44
• Outpatient	$100 outpatient facility surgery copayment per episode	45
Emergency benefits:		
• In-area	$75 copayment per emergency room visit	49
• Out-of-area	$75 copayment per emergency room visit	49
Mental health and substance abuse treatment:	Regular cost sharing	51
Prescription drugs:	$50 deductible per person ($150 per family)	54
• Retail pharmacy	$5/$35/$60 copayment for up to a **30-day** supply	56
• Mail order	$10/$70/$120 copayment for up to a **90-day** supply	56
• Specialty pharmacy	$5/$35/$60 copayment for up to a **30-day** supply	56
Dental care: We cover restorative services and supplies necessary to promptly repair (but not to replace) sound natural teeth. The need for these services must result from an accidental injury.	No benefit.	59
Vision care:	No benefit.	29

Standard Option Benefits	You Pay	Page
Special features: BlueCard Urgent Care-Out of Area Services; BlueCard Follow-Up Services-Out of Area Services; Out-of-Counrty Services; Away From Home Care-Guest Membership; Nurse Line; Healthy Family Fun/Blue365; and www.capbluecross.com.		60
Protection against catastrophic costs (out-of-pocket maximum)**:**	We do not have an out-pocket maximum	81

2009 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 to Federal Benefits for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employers. Most employees should refer to the Guide to Benefits *for Career* United States Postal Service Employees, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 Guide to Federal Benefits.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	S41	155.66	121.84	337.26	263.99	179.45	98.05
High Option Self and Family	S42	352.56	310.52	763.88	672.79	406.42	256.66
Standard Option Self Only	S44	155.66	99.26	337.26	215.07	179.45	75.47
Standard Option Self and Family	S45	352.66	255.49	763.88	553.56	406.42	201.63