

Keystone Health Plan East

www.ibx.com/fep



2009

A Health Maintenance Organization

Serving:

The Philadelphia area

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 9 for requirements.

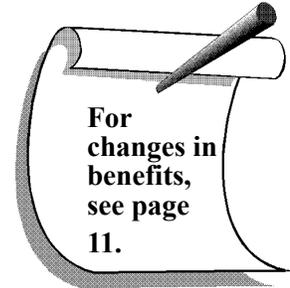
Enrollment codes for this Plan:

ED1 High Option Self Only

ED2 High Option Self and Family

ED4 Standard Option Self Only

ED5 Standard Option High Self and Family



This Plan has excellent accreditation from the NCQA. See the 2009 Guide for more information on accreditation.

Authorized for distribution by the:



**United States
Office of Personnel Management**

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



RI 73-483

**Important Notice from Keystone Health Plan East About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the Keystone Health Plan East 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 in 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 East under our contract (CS 2339) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross, independent licensee of the Blue Cross and Blue Shield Association. The address for administrative offices is:

Keystone Health Plan East, Inc
1901 Market Street
Philadelphia, PA 19103

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 11. 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 East.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

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

Stop Health Care Fraud!

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

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

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

- 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 1-800-227-3114 and explain the situation.
 - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

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

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- 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.

Want more information on patient safety? 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.

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

Our HMO reimbursement programs for health care providers are intended to encourage the provision of quality, cost-effective care for our Members. Set forth below is a general description of our HMO reimbursement programs, by type of participating health care provider. These programs vary by state. Please note that these programs may change from time to time, and the arrangements with particular providers may be modified as new contracts are negotiated. If after reading this material you have any questions about how your health care provider is compensated, please speak with them directly or contact us.

Utilization Review Process

A basic condition of the HMO's benefit plan is that in order for a health care service to be covered or payable, the services must be Medically Necessary. To assist the HMO in making coverage determinations for requested health care services, the HMO uses established medical guidelines based on clinically credible evidence to determine the Medical Necessity of requested services. The appropriateness of the requested setting in which the services are to be performed may also be assessed. This process of determining the Medical Necessity of requested health care services for coverage determinations is called utilization review. The use of Medical Necessity criteria based on clinically credible evidence for this process promotes a balance of access to quality care, medically appropriate utilization and coverage based on the benefits available under our Members' benefit plans.

Utilization review includes several components, which are based on when the review is performed. When the review is required before a service is performed it is called a pre-service review. Reviews occurring during a hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. The HMO follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, nurses perform initial case review and evaluation for coverage approval using established guidelines and evidence-based clinical criteria and protocols; however only a Medical Director may deny coverage for a procedure based on Medical Necessity. The evidence-based clinical protocols evaluate the medical appropriateness of specific procedures and the majority of clinical protocols are computer-based. Information provided in support of the request is entered into clinical pathways that assist in the review of Medical Necessity of the request. Nurses apply all pertinent health plan policies and procedures, taking into consideration individual factors relevant to a given Member and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a Medical Director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of Medical Necessity, the rationale for the denial and the appeals process is explained to the requestor, and a confirmation letter is sent to the requesting Provider and Member in accordance with applicable law.

Our utilization review program encourages peer dialogue regarding coverage decisions based on Medical Necessity by providing Physicians with direct access to plan Medical Directors to discuss coverage of a case. The nurses, Medical Directors, other professional providers, and independent medical consultants who perform utilization review services are not compensated or given incentives based on their coverage review decisions. Medical Directors and nurses are salaried and contracted external physician and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. The HMO does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals, which would encourage utilization review decisions that result in underutilization.

Pre-Service Review

Pre-service review evaluates the Medical Necessity and coverage for services, which have not yet been performed. Examples of these services include planned or elective inpatient admissions and selected outpatient procedures. This proactive opportunity, which may be initiated by the Provider or the Member depending on the benefit plan, is utilized to assure that all elective care is Medically Necessary and performed in the most appropriate setting. Pre-service review is not required for Emergency Services or a maternity Inpatient stay.

The following are general examples of current Pre-service requirements:

- Elective inpatient admissions
- Outpatient surgeries/procedures performed in a facility setting
- Requests for Members to use other than their Designated Providers for those services provided by Designated Providers
- Requests to use Non-Participating Providers
- Potentially cosmetic procedures
- Infusion performed in a facility setting

Concurrent Review

Concurrent Review is performed while services are being performed. This may occur during an inpatient stay. The review evaluates the expected and current length of stay to determine if continued hospitalization is Medically Necessary. The review assesses the level of care provided to the Member and coordinates discharge planning. Concurrent review continues until the patient is discharged.

Retrospective/Post-Service Review

Retrospective review occurs after services have been provided. This may be for a variety of reasons, including the Plan not being notified of a Member's admission until after discharge or where medical charts are unavailable at the time of concurrent review.

Professional Providers

Primary Care Physicians: Most Primary Care Physicians (PCPs) are paid in advance for their services, receiving a set dollar amount per Member, per month for each Member selecting that PCP. This is called a "capitation" payment and it covers most of the care delivered by the PCP. Covered Services not included under capitation are paid fee-for-service according to the HMO fee schedule. Many Pennsylvania based PCPs are also eligible to receive additional payments for meeting certain medical quality, patient service, and other performance standards. The PCP Quality Incentive Payment System (QIPS) includes incentives for practices that have extended hours and submit encounter and referral data electronically, as well as an incentive that is based on the extent to which a PCP prescribes generic drugs (when available) relative to similar PCPs. In addition, the Practice Quality Assessment Score focuses on preventive care and other established clinical interventions.

Referred Specialists: Most Specialists are paid on a fee-for-service basis, meaning that payment is made according to our HMO fee schedule for the specific medical services that the Referred Specialist performs. Obstetricians are paid global fees that cover most of their professional services for prenatal care and for delivery.

Designated Providers: For a few specialty services, PCPs are required to select a Designated Provider to which they refer all of our HMO patients for those services. The specialist services for which PCPs must select a Designated Provider vary by state and could include, but are not limited to, radiology, physical and occupational therapy, and podiatry. Designated Providers usually are paid a set dollar amount per Member per month (capitation) for their services based on the PCPs that have selected them. Before selecting a PCP, HMO Members may want to speak to the PCP regarding the Designated Providers that PCP has chosen.

Institutional Providers

Hospitals: For most inpatient medical and surgical Covered Services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Member is in the Hospital. These rates usually vary according to the intensity of services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete hospital stay related to a specific procedure or diagnosis, e.g., transplants. For most outpatient and emergency Covered Services and procedures, most Hospitals are paid specific rates based on the type of service performed. Hospitals may also be paid a global rate for certain outpatient services (e.g., lab and radiology) that includes both the facility and physician payment. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various Covered Services.

Some Hospitals participate in a quality incentive program. The program provides increased reimbursement to the Hospitals when they meet specific quality and other criteria, including “Patient Safety Measures.” Such patient safety measures are consistent with recommendations by The Leap Frog Group, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Agency for Health Care Research and Quality (AHRQ) and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes and electronic submissions. This new incentive program is expected to evolve over time.

Skilled Nursing Homes, Rehabilitation Hospitals, and other care facilities: Most Skilled Nursing Facilities and other special care facilities are paid per diem rates, which are specific amounts paid for each day a Member is in the facility. These amounts may vary according to the intensity of services provided.

Ambulatory Surgical Centers (ASCs)

Most ASCs are paid specific rates based on the type of service performed. For a few Covered Services, some ASCs are paid based on a percentage of billed charges.

Integrated Delivery Systems

In a few instances, global payment arrangements are in place with integrated hospital/physician organizations called Integrated Delivery Systems (IDS). In these cases the IDS provides or arranges for some of the Hospital, physician and ancillary Covered Services provided to some of our Members who select PCPs which are employed by or participate with the IDS. The IDS is paid a global fee to cover all such Covered Services, whether provided by the IDS or other providers. These IDSs are therefore “at risk” for the cost of these Covered Services. Some of these IDSs may provide incentives to their IDS-affiliated professional providers for meeting certain quality, service or other performance standards.

Physician Group Practices and Physician Associations

Certain physician group practices and independent physician associations (IPAs) employ or contract with individual physicians to provide medical Covered Services. These groups are paid as outlined above. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or other performance standards. In Pennsylvania, we have entered into a joint venture with an IPA. This IPA is paid a global fee to cover the cost of all Covered Services, including Hospital, professional and ancillary Covered Services provided to Members who choose a PCP in this IPA. This IPA is therefore “at risk” for the cost of these Covered Services. This IPA provides incentives to its affiliated physicians for meeting certain quality, service and other performance standards.

Ancillary Service Providers

Some ancillary service providers, such as Durable Medical Equipment and Home Health Care Providers, are paid fee-for-service payments according to our HMO fee schedule for the specific medical services performed. Other ancillary service providers, such as those providing laboratory, Covered Services, are paid a set dollar amount per Member, per month (capitation). Capitated ancillary service vendors are responsible for paying their contracted providers and do so on a fee-for-service basis.

Mental Health/Substance Abuse

A mental health/substance abuse (“behavioral health”) management company administers most of our behavioral health Covered Services, provides a network of participating behavioral health care providers and processes related claims. The behavioral health management company is paid a set dollar amount per Member, per month (capitation) for each Member and is responsible for paying its contracted providers on a fee-for-service basis. The contract with the behavioral health management company includes performance-based payments related to quality, provider access, service, and other such parameters. A subsidiary of Independence Blue Cross has a less than one percent ownership interest in this behavioral health management company.

Prescription Drug Program Provider Payment Information

A pharmacy benefits management company (PBM), which is affiliated with Independence Blue Cross, administers our prescription drug benefits, and is responsible for providing a network of Participating Pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. Independence Blue Cross anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of pharmacy benefits. Under most benefit plans, prescription drugs are subject to a member copayment.

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.

If you want more information about us, call 1-800-227-3114, or write to Keystone Health Plan East, 1901 Market Street, Philadelphia, Pennsylvania 19103. You may also visit our Web site at www.ibx.com/fep.

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 utilization) to any of your treating physician 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: The **Pennsylvania** counties of Bucks, Chester, Montgomery, Delaware and Philadelphia.

You are required to select a personal doctor from among participating plan primary care doctors located within the Plan’s service area. Please note that if you reside in New Jersey and work in Pennsylvania within our service area, you must select a primary care doctor whose practice is in Pennsylvania within our service area. Your dependents may select a personal doctor from among participating plan primary care doctors in Pennsylvania or New Jersey. You and your dependents may have only one dentist who must be selected from a list of participating plan dentists located within the Plan’s service area.

Ordinarily, you must get your care from providers who contract with us, except for emergency care required while you are outside our Service Area. However, as a Keystone Health Plan East member, you have access to urgent care and urgent follow-up care through a nationwide network of Blue Cross[®] and Blue Shield[®] providers. If you become ill while visiting outside our Service Area, call 1-800/810-BLUE to find names and addresses of nearby participating Blue Cross[®] and Blue Shield[®] providers. This number is also found on the back of your ID card. Before you obtain urgent care, call Patient Care Management at the phone number on your ID Card to have the care preauthorized. An office visit copayment will be collected when the service is rendered. You will not need to file a claim.

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. Through our Guest Membership benefit, members who are away from home for at least 90 days may temporarily enroll in another Blue Cross[®] and Blue Shield[®] network HMO.

Members are also eligible for Guest Membership for up to six months if, for example, they are assigned out-of-area temporarily. Guest Membership enables members to receive the full range of HMO benefits and services offered by the hosting HMOs. To enroll, members simply contact their Guest Membership Coordinator in advance. The phone number is on the back of the ID Card. The Coordinator will make all the necessary arrangements for Guest Membership and take care of all the billing details. Also, your prescription drug card works in more than 60,000 pharmacies in the United States. 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.

Section 2. How we change for 2009

Do not rely only on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to High Option

Your share of the non-Postal premium will increase for Self Only and for Self and Family. See back cover.

You will now pay a \$100 copayment per visit for the emergency room.

You will now pay \$5 per covered generic formulary brand prescription/refill (up to a 30 day supply), at a Plan Retail Pharmacy. .

You will now pay \$50 per covered non-formulary brand prescription/refill (up to a 30 day supply), at a Plan Retail Pharmacy.

You will now pay \$10 per covered generic formulary prescription/refill (for a 31 to 90 day supply), through the Plan Mail Order Pharmacy.

You will now pay \$100 per covered non-formulary brand prescription/refill (for a 31 to 90 day supply), through the Plan Mail Order Pharmacy.

Changes to Standard Option

Your share of the non-Postal premium will increase for Self Only and for Self and Family. See back cover.

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 1-800-227-3114 or write to us at Keystone Health Plan East, 1901 Market Street, Philadelphia, PA 19103. You may also request replacement cards through our Web site at www.ibx.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance; you will not have to file claims.

- **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.

- **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.

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.

It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a referral by the member’s primary care doctor except for: dental care, vision care, and visits to the OB/GYN for preventive care, routine maternity care or problems related to gynecological conditions when medically necessary such as, reproductive endocrinology, infertility and gynecological oncology.

Treatment for mental conditions and substance abuse may be obtained directly from Magellan Behavioral Health. Magellan Behavioral Health, or any other mental health administrator for Keystone Health Plan East, manages all care related to mental health and substance abuse services and will determine what specialty care is appropriate and which specialists will be utilized. Questions about related benefits and precertification should be directed to Magellan Behavioral Health at 1-800-688-1911.

- **Primary care**

Your primary care physician can be a family practitioner, internist, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

All services must be received from Keystone Participating Providers unless Preapproved by the HMO, or except in cases requiring Emergency Services or Urgent Care while outside the Service Area. See “Access to Specialist and Hospital Care” for procedures for obtaining Preapproval for use of a non-Participating Provider. Use your Provider Directory to find out more about the individual Providers, including Hospitals and Primary Care Physicians and Referred Specialists and their affiliated Hospitals. It includes a foreign language index to help you locate a Provider who is fluent in a particular language. The directory also lists whether the Provider is accepting new patients.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you may visit the specialist as many times as necessary as long as the visit is within 90 days of the initial visit. However, you may get dental care, vision care, mammograms, and see an obstetrician/ gynecologist for preventive care, routine maternity care or problems related to gynecological conditions when medically necessary, without a referral.

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. Services by non-Participating Providers require Preapproval by the HMO in addition to the written Referral from your Primary Care Physician.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan;

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

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

- **Hospital care**

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

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 1-800-227-3114. 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.

Circumstances beyond our control

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

• **Services requiring our prior approval**

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

We call this review and approval process preauthorization. Your physician must obtain preauthorization for the following services such as:

- All non-emergency hospital admissions
- Organ/tissue transplants
- All same day surgery/short procedure unit admissions
- Morbid Obesity (Bariatric Surgery)
- Outpatient therapies: speech, cardiac, pulmonary, respiratory, home infusion
- Other facility services: skilled nursing, home health, hospice, birthing center
- Rental/purchase of durable medical equipment and prostheses (purchases over \$500.00 and all rentals)
- Non-emergency ambulance services
- Inpatient psychiatric care
- Inpatient alcohol and substance abuse treatment
- Some medications that have specific uses and are administered in outpatient settings or physician offices
- Biotech/Specialty Injectables

Members are not responsible for payment of services if the provider does not obtain preauthorization of services.

• **Preapproval for Non-Participating Providers**

The HMO may approve payment for Covered Services provided by a non-Participating Provider if you have:

- (1) First sought and received care from a Participating Provider in the same American Board of Medical Specialties (ABMS) recognized specialty as the non-Participating Provider that you have requested (a Referral from your Primary Care Physician is required);
- (2) Been advised by the Participating Provider that there are no Participating Providers that can provide the requested Covered Services; and
- (3) Obtained authorization from the HMO prior to receiving care. The HMO reserves the right to make the final determination whether there is a Participating Provider that can provide the Covered Services.

If the HMO approves the use of a non-Participating Provider, you will not be responsible for the difference between the Provider's billed charges and the HMO's payment to the Provider but you will be responsible for applicable copayments, coinsurance and/or deductibles. Applicable program terms including Medical Necessity, Referrals and Preapproval by the HMO, when required, will apply.

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 services.

Example: If you have High Option, when you see your primary care physician, you pay a copayment of \$20 per office visit or a copayment of \$25 per office visit when you see a specialist.

If you have Standard Option, when you see your primary care physician, you pay a copayment of \$20 per office visit or a copayment of \$40 per office visit when you see a specialist.

Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.

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 amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward your deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply that you pay counts toward meeting your deductible.

Under Standard Option, the calendar year deductible is \$500 per person. Under a family enrollment, the calendar year deductible for each family member is satisfied and benefits are payable for all family members when the combined covered expenses of the family reach \$1500.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is \$300, the provider has an agreement with us to accept \$220, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you may pay \$220. We will apply \$220 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible (\$280) has been satisfied.

Under High Option, there is **no calendar year deductible**.

Coinsurance Coinsurance is the percentage of the HMO fee schedule amount, which must be paid by the Member (such as 20 percent). Under Standard Option only, coinsurance does not begin until you meet your deductible.

Example: You pay 20 percent of the HMO fee schedule under Standard Option for outpatient surgery, after meeting your \$500 calendar year deductible.

Your catastrophic protection out-of-pocket maximum **Under High Option**, after your copayment of \$2,000 per person or \$4,000 per family has been reached in a calendar year, or **under Standard Option**, \$3,000 per person or \$9,000 per family, you will be reimbursed for any copayment and coinsurance amounts paid thereafter, following submission of paid receipts. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs
- Dental services

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

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

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 the important thing you should keep in mind at the beginning of each subsection. Also read the General Exclusion in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800-227-3114 or at our website at www.ibx.com/fep

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**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 physician must provide or arrange your care.
- 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.
- **Under Standard Option**, the calendar year deductible is \$500 per person, \$1,500 per family. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Preapproval, when required.

Benefit Description	You pay	
	High Option	Standard Option
Diagnostic and treatment services		
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • Second surgical opinion 	\$20 per visit to your primary care physician \$25 per visit to a specialist	\$20 per visit to your primary care physician (No deductible) \$40 per visit to a specialist (No deductible)
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility 	Nothing	20% after deductible has been met
At home	\$25 per visit	\$20 per visit to your primary care physician (No deductible) \$40 per visit from a specialist (No deductible)
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Charges for completion of insurance forms</i> • <i>Charges for missed appointments</i> 	<i>All charges</i>	<i>All charges</i>
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Pathology • Urinalysis • Non-routine pap tests • Non-routine Mammograms 	Nothing	Nothing (No deductible)
X-rays Ultrasound Electrocardiogram and EEG	\$25 copayment	\$40 copayment (No deductible)
CAT Scans/MRI	\$25 copayment	\$80 copayment (No deductible)

Benefit Description	You pay	
	High Option	Standard Option
Injectable Medications		
Standard Injectables	Nothing	Nothing
Biotech/Specialty Injectables	Nothing	<p>\$100 copayment (No deductible)</p> <p>Copayment amounts will apply:</p> <ul style="list-style-type: none"> To each thirty day supply of medication dispensed for medications administered on a regularly scheduled basis; To each course/ series of injections if administered on an intermittent basis. <p>A ninety (90) day supply of medication may be dispensed for some medications that are used for the treatment of a chronic illness; in such a case, the Member will be subject to three (3) copayments.</p>
Preventive care, adult	High Option	Standard Option
<p>Routine screenings, based on medical necessity and risk such as:</p> <ul style="list-style-type: none"> Total Blood Cholesterol Colorectal Cancer Screening, including <ul style="list-style-type: none"> Fecal occult blood test Sigmoidoscopy, screening – every five years starting at age 50 Colonoscopy once every 10 years starting at age 50 Double contrast barium enema (DCBE) once every 5-10 years starting at age 50. Prostate Specific Antigen (PSA test) – one annually for men age 40 and older Mammograms, annually 	\$20 per office visit	\$20 per office visit (No deductible)
<p>Routine pap test</p> <p>Note: The office visit is covered if pap test is received on the same day; see Diagnostic and Treatment services, above.</p>	\$20 per office visit to your primary care physician; \$25 per visit to a specialist; nothing for the test	\$20 per office visit to your primary care physician; \$40 per visit to a specialist; nothing for the test (No deductible)
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) and approved by Keystone.	\$20 per office visit	\$20 per office visit (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Preventive care, adult (cont.)		
<i>Not covered: Physical exams and immunization required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>	<i>All charges</i>
Preventive care, children		
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	\$20 per office visit	\$20 per office visit (No deductible)
<ul style="list-style-type: none"> Well-child care charges for routine eye screenings by Primary Care Physician, immunizations and care (up to age 22) Examinations, such as: <ul style="list-style-type: none"> Eye screening by Primary Care Physician through age 17 to determine the need for vision correction Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) 	\$20 per office visit	\$20 per office visit (No deductible)
Maternity care		
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Postnatal care Delivery <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. Coverage is also provided for at least one Home Health Care visit following an inpatient release for maternity care when the Member is released prior to 48 hours for a normal delivery and 96 hours for a cesarean delivery. 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. Surgical benefits, not maternity benefits, apply to circumcision. 	\$25 copayment for the initial visit	\$20 copayment for the initial visit (No deductible) Hospital 20% after deductible has been met

Maternity care - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Maternity care (cont.)		
We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	\$25 copayment for the initial visit	\$20 copayment for the initial visit (No deductible) Hospital 20% after deductible has been met
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges</i>	<i>All charges</i>
Family planning	High Option	Standard Option
A range of voluntary family planning services, limited to: <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives. Insertion and removal covered under medical benefit. Drug covered under the Prescription Drug benefit • Injectable contraceptive drugs (such as Depo provera) — covered under the Prescription Drug benefit. • Intrauterine devices (IUDs) • Diaphragms • Genetic counseling <p>Note: We cover oral and injectable contraceptive drugs and contraceptive devices through the prescription drug benefit (See Prescription Drug Benefits Section 5(f)). Under High Option, contraceptive devices are also covered through the medical benefit. Under Standard Option, contraceptive devices are not covered through the medical benefits.</p>	\$25 per office visit \$25 per specialist office visit; nothing when the device is implanted during a covered hospitalization	\$40 per office visit (No deductible) \$40 per specialist office visit; nothing when the device is implanted during a covered hospitalization (No deductible)
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Removal of surgically implanted time-release medication before the end of the expected life, unless medically necessary and approved by the Plan.</i> 	<i>All charges</i>	<i>All charges</i>
Infertility services	High Option	Standard Option
Diagnosis and treatment of infertility such as: <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - <i>intravaginal insemination (IVI)</i> - <i>intra-cervical insemination (ICI)</i> - <i>intrauterine insemination (IUI)</i> • Fertility drugs 	\$25 per office visit	\$40 per office visit (No deductible)

Infertility services - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Infertility services (cont.)		
Note: We cover non-injectable (oral) fertility drugs under the Prescription drug benefit. A Referral is required for specialty care provided by a reproductive endocrinologist, infertility specialist, or gynecological oncologist.	\$25 per office visit	\$40 per office visit (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges</i>	<i>All charges</i>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	\$25 per office visit	\$40 per office visit (No deductible)
Allergy serum	Nothing	20% after deductible has been met
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>	<i>All charges</i>
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 31.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: We will only cover GHT when we preauthorize the treatment. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	Nothing	20% after deductible has been met

Benefit Description	You pay	
	High Option	Standard Option
<p>Physical and occupational therapies</p> <ul style="list-style-type: none"> • Therapy rendered within 60 consecutive days per condition for the services of each of the following if significant improvement can be expected in the two month period <ul style="list-style-type: none"> - qualified physical therapists; - occupational therapists; - hand therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 12 weeks.</p>	\$25 per visit	\$40 copayment (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges</i>	<i>All charges</i>
<p>Speech therapy</p> <ul style="list-style-type: none"> • Therapy rendered within 60 consecutive days per condition for the services of qualified speech therapists 	\$25 per visit	\$40 copayment (No deductible)
<p>Hearing services (testing, treatment, and supplies)</p> <ul style="list-style-type: none"> • Hearing screening by Primary Care Physician for children through age 17 (see <i>Preventive care, children</i>) 	\$20 per office visit	\$20 per office visit (No deductible)
<p><i>Not covered:</i></p> <p><i>Hearing or audiometric examinations, and Hearing Aids, including cochlear electromagnetic hearing devices and the fitting thereof; and, routine hearing examinations; Services and supplies related to these items are not covered.</i></p>	<i>All charges</i>	<i>All charges</i>
<p>Vision services (testing, treatment, and supplies)</p> <p>Please Note: Routine eye exam and eyewear available once every two calendar years. Contact lenses are available in lieu of eyeglasses. Benefits are maximized by using a Davis Vision participating provider.</p> <ul style="list-style-type: none"> • One eye exam and refraction at a participating provider, every two calendar years 	\$25 per specialist office visit	\$40 per specialist office visit (No deductible)

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

Benefit Description	You pay	
	High Option	Standard Option
Vision services (testing, treatment, and supplies) (cont.)		
<ul style="list-style-type: none"> • Frames and corrective lenses once every two calendar years. 	All charges after Plan's \$35 allowance every two calendar years	All charges after Plan's \$35 allowance every two calendar years
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	Nothing	Nothing
<ul style="list-style-type: none"> • Eye screening by Primary Care Physician to determine the need for vision correction for children through age 17 (see preventive care) 	\$20 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Contact lens fittings</i> • <i>Eye exercises</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>	<i>All charges</i>
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.	\$25 per office visit	\$40 per office visit (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>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)</i> 	<i>All charges</i>	<i>All charges</i>
Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> • Artificial limbs; limited to initial device only; stump hose • Artificial lenses following cataract surgery • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, 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. • Braces; limited to initial purchase and fitting 	Nothing	50% after deductible has been met
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic and corrective shoes</i> 	<i>All charges</i>	<i>All charges</i>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • arch supports • foot orthotics, unless for treatment of diabetes • heel pads and heel cups • lumbosacral supports • corsets, trusses, elastic stockings, support hose, and other supportive devices • dental prostheses • cranial prostheses including wigs and other devices intended to replace hair 	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)	High Option	Standard Option
<p>Rental, or at our option, the initial purchase per medical episode, when medically necessary, including repair, and replacement, adjustment, of standard durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • standard hospital beds • wheelchairs – including motorized wheelchairs • crutches • walkers • blood glucose monitors; and • insulin pumps 	Nothing	50% after deductible has been met
<p><i>Not covered:</i></p> <p><i>Customized durable medical equipment</i></p>	<i>All charges</i>	<i>All charges</i>
Home health services	High Option	Standard Option
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a licensed Home Health Care agency. • Private Duty Nursing Services performed by a licensed register Nurse (R.N.), or a licensed practical nurse (L.P.N.), when ordered by your Primary Care Physician, or a referred Specialist as a part of Home Health Care treatment Plan and which are Medically Necessary. • Services include oxygen therapy, intravenous therapy and medications. <p>Note: Under Standard Option, Outpatient Private Duty Nursing is limited to 360 hours per calendar year.</p>	Nothing	20% after deductible has been met
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges</i>	<i>All charges</i>

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- 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.

Benefit Description	You pay	
	High Option	Standard Option
<p>Surgical procedures</p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (Bariatric Surgery) — a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. <p>Note: If you need additional information on the criteria that must be met for surgical treatment of morbid obesity, you can reach our Website at http://www.ibx.com/providers/policies_guidelines_pubs/medical_policy.html</p> <ul style="list-style-type: none"> • 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	20% after deductible has been met

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	High Option	Standard Option
<p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	Nothing	20% after deductible has been met
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All Charges</i>	<i>All charges</i>
Reconstructive surgery	High Option	Standard Option
<p>Your physician must obtain approval from us before providing service for these conditions:</p> <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery; • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities, cleft lip, cleft palate, birth marks, webbed fingers, and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	Nothing	20% after deductible has been met
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All Charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
Oral and maxillofacial surgery		
<p>Oral surgical procedures require preapproval by the Plan and are limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and <p>Other surgical procedures that do not involve the teeth or their supporting structures.</p>	Nothing	20% after deductible has been met
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges</i>	<i>All charges</i>
Organ/tissue transplants		
<p>Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas 	Nothing	20% after deductible has been met
<p>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.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Hemoglobinopathy (i.e., Franconi's, Thalessemia major) 	Nothing	20% after deductible has been met

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma - Amyloidosis • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) <p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing	20% after deductible has been met
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<i>All Charges</i>	<i>All charges</i>
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing	20% after deductible has been met

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).

Benefit Description	You pay	
	High Option	Standard Option
<p>Inpatient hospital</p> <p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: Pre-authorization is required for all inpatient admissions other than maternity and emergency admissions. If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>\$125 copayment per day up to \$625 maximum per admission (waived if readmitted within 90 days of discharge for same diagnosis)</p>	<p>20% after deductible has been met per admission</p> <p>Deductible per calendar year \$500 Individual \$1500 Family</p>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items <p>Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</p>	<p>Nothing</p>	<p>20% after deductible has been met</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> 	<p><i>All Charges</i></p>	<p><i>All charges</i></p>

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All Charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	High Option	Standard Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$100 copayment only	20% after deductible has been met
Extended care benefits/Skilled nursing care facility benefits	High Option	Standard Option
<p>Extended care benefit:</p> <p>Under High Option, we provide a comprehensive range of benefits for up to 180 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.</p> <p>Under Standard Option, we cover up to 120 days per calendar year.</p>	\$125 copayment per day up to \$625 maximum if admitted directly to skilled nursing facility	20% after deductible has been met
<p>Not covered: custodial care, rest cures, domiciliary or convalescent care, personal comfort items, such as telephones and television</p>	<i>All charges</i>	<i>All charges</i>
Hospice care	High Option	Standard Option
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p> <p>Respite care</p>	<p>\$125 copayment per day up to \$625 maximum if admitted directly to Hospice</p> <p>Nothing</p>	<p>20% after deductible has been met</p> <p>20% after deductible has been met</p>

Hospice care - continued on next page

High and Standard Option

Benefit Description	You pay	
Hospice care (cont.)	High Option	Standard Option
When Hospice Care is provided in the home, care on a short-term Inpatient basis in a Medicare Certified Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the patient's home.	Nothing	20% after deductible has been met
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges</i>	<i>All charges</i>
Ambulance	High Option	Standard Option
Local professional ambulance service when medically appropriate and authorized by a Plan doctor. Note: Pre-authorization required for non-emergency ambulance service.	Nothing	20% after deductible has been met

Section 5(d) Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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?

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

What to do in case of emergency:

Emergencies within our service area:

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room.

If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

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

Emergencies outside our service area:

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

If you need to be hospitalized, the Plan must be notified. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

High and Standard Option

Benefit Description	You pay	
Emergency within our service area	High Option	Standard Option
Emergency care at a doctor's office	\$20 per office visit	\$20 per office visit (No deductible)
Emergency care as an outpatient or inpatient at a hospital, including doctors' services	\$100 per visit; waived if admitted to a hospital or if you are referred to the ER by your PCP and services could have been provided by your doctor, a copayment of \$20 required	20% after deductible has been met (not waived if admitted)
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>	<i>All charges.</i>
Emergency outside our service area	High Option	Standard Option
Emergency care at a doctor's office	\$20 per office visit	\$20 per office visit
Emergency care as an outpatient or inpatient at a hospital, including doctors' services	\$100 per visit; waived if admitted to hospital	20% after deductible has been met (not waived if admitted)
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>	<i>All charges.</i>
Ambulance	High Option	Standard Option
Professional ambulance, or air ambulance service, when medically appropriate. See 5(c) for non-emergency service	Nothing	20% after deductible has been met

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 you should keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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 Description	You pay	
	High Option	Standard Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Substance Abuse Treatment</p> <p>Benefits are provided for Covered Services during an Outpatient Substance Abuse Treatment visit/session for the diagnosis and medical treatment of Substance Abuse, including Detoxification in an acute care Hospital or a Substance Abuse treatment Facility that is a Behavioral Health/Substance Abuse Provider.</p> <p>Benefits are also provided for Covered Services for non-medical treatment, such as vocational rehabilitation or employment counseling during an Outpatient Substance Abuse Treatment visit/session in a Substance Abuse Treatment Facility that is a Behavioral Health/Substance Abuse Provider.</p> <p>A Referral from your Primary Care Physician is not required. Contact your Primary Care Physician or call the behavioral health management company at the phone number on the back of the ID Card.</p> <p>Outpatient Substance Abuse Treatment Covered Services provided in an acute care Hospital or a Substance Abuse Treatment Facility that is a Behavioral Health/Substance Abuse Provider, include:</p> <ul style="list-style-type: none"> • Professional services, including psychiatric and psychological services provided by the Behavioral Health/Substance Abuse Providers on staff; • Rehabilitation therapy and counseling • Family counseling and intervention • Medication management <p>Supplies and use of equipment provided by the Substance Abuse Treatment Facility</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p> <p>\$25 per specialist office visit</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p> <p>\$40 per specialist office visit (No deductible)</p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Diagnostic services and medical tests <p>Laboratory tests</p> <p><i>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.</i></p>	Nothing	\$40 copayment (No deductible) Nothing
<ul style="list-style-type: none"> Services provided by a hospital or other facility 	Nothing	20% after deductible has been met
<ul style="list-style-type: none"> Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment 	\$125 copayment per day up to \$625 maximum per admission waived if readmitted within 90 days for same diagnosis	20% after deductible has been met
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will have base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges</i>	<i>All charges</i>

Preauthorization

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

Treatment for mental conditions, including various mental illnesses and substance abuse, is coordinated directly by Magellan Behavioral Health, or any other behavioral health administrator we designate. Magellan Behavioral Health, acting as our mental health administrator, manages all care related to mental health and substance abuse services. Questions about related benefits and precertification should be directed to Magellan Behavioral Health at 1-800-688-1911.

Limitation

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

Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.

Be sure to read Section 4, *your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan Retail pharmacy, by mail through the Plan mail order pharmacy for maintenance medications, or at a non-plan retail pharmacy for a higher out of pocket expense except for prescriptions required because of an out-of-area emergency, which will be covered at the plan retail pharmacy level .
- **We use a formulary.** Drugs are prescribed by licensed doctors and dispensed in accordance with the Plan's formulary. The Plan formulary includes all covered generic drugs and a list of selected brand drugs that have been evaluated for their medical effectiveness, safety and value. The Plan formulary is designed to include all therapeutic categories, provide coverage for all types of drugs and provide physicians with prescribing options.
- **Prior Authorization.** Your pharmacy benefits plan requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to the Food and Drug Administration (FDA) guidelines. The approval criteria was developed and endorsed by the FutureScripts Pharmacy and Therapeutics Committee, which is an established group of Medical Directors and practicing area physicians and pharmacists.
- **These are the dispensing limitations.** Covered prescription drugs prescribed by a licensed doctor or dentist and obtained at a Plan Retail pharmacy will be dispensed for up to a 30-day supply, or the maximum allowed dosage as prescribed by law, whichever is less. Covered maintenance drugs may be obtained through the Plan mail order pharmacy for up to a 90-day supply. Prescription refills will be dispensed only if 75% of the previously dispensed quantity has been consumed based on the dosage prescribed. If you are in the military and called to active duty due to an emergency, please contact us if you need assistance in filling a prescription before your departure.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand product. Generics cost less than the equivalent brand product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand drugs. You can save money by using generic drugs. However, you and your physician have the option to request a brand, even if a generic option is available. Using the most cost-effective medication saves money.
- **When you have to file a claim.** Prescription drugs obtained from a non-Plan Retail pharmacy are eligible with a higher out of pocket expense, except for an out of area emergency which will be reimbursed after your copayment. You must submit acceptable proof-of-payment with a direct reimbursement form. All claims for payment must be received within ninety (90) days of the date of proof-of-purchase. **Direct reimbursement forms may be obtained by calling 1-888-678-7012.**

Benefit Description	You pay	
Covered medications and supplies	High Option	Standard Option
<p>We cover the following medications and supplies prescribed by a licensed physician, or licensed dentist, and obtained from a Plan Retail pharmacy or through the plan mail order pharmacy:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Oral and injectable contraceptive drugs – up to a three-cycle supply for a single copayment. • Contraceptive diaphragms and IUDs • Insulin • Diabetic supplies, including disposable insulin needles and syringes, glucose test tablets and test tape, Benedict’s solution or equivalent, acetone test tablets, diabetic blood testing strips, lancets and glucometers. Copayment applies to each diabetic supply, except lancets and glucometers obtained through a Plan Participating Pharmacy. • Disposable needles and syringes for the administration of covered medications. • Prenatal and pediatric vitamins • Non-injectable (oral) fertility drugs • Drugs to treat sexual dysfunction (may be subject to dosage limitations, contact the Plan for dose limits.) 	<p><u>At a Plan Retail Pharmacy:</u></p> <p>\$5 per covered generic formulary prescription/refill (up to a 30 day supply)</p> <p>\$20 per covered brand formulary prescription/refill (up to a 30 day supply)</p> <p>\$50 per covered non-formulary brand prescription/refill (up to a 30 day supply)</p> <p><u>Through the Plan Mail Order Pharmacy:</u></p> <p>\$10 per covered generic formulary prescription/refill for a 31 to 90 day supply through mail order (maintenance medications only)</p> <p>\$40 per covered brand formulary prescription/refill for a 31 to 90 day supply through mail order (maintenance medications only)</p> <p>\$100 per covered non-formulary brand prescription/refill for a 31 to 90 day supply through mail order (maintenance medications only)</p> <p><u>At a Non-Plan Retail Pharmacy:</u></p> <p>70% of the total cost of the drug except emergency prescription purchases, which are covered at 100% less, the appropriate copayment as indicated above.</p>	<p><u>At a Plan Retail Pharmacy:</u></p> <p>\$20 per covered generic formulary prescription/refill (up to a 30 day supply)</p> <p>\$40 per covered brand formulary prescription/refill (up to a 30 day supply)</p> <p>\$60 per covered non-formulary brand prescription/refill (up to a 30 day supply)</p> <p><u>Through the Plan Mail Order Pharmacy:</u></p> <p>\$40 per covered generic formulary prescription/refill for a 31 to 90 day supply through mail order (maintenance medications only)</p> <p>\$80 per covered brand formulary prescription/refill for a 31 to 90 day supply through mail order (maintenance medications only)</p> <p>\$120 per covered non-formulary brand prescription/refill for a 31 to 90 day supply through mail order (maintenance medications only)</p> <p><u>At a Non-Plan Retail Pharmacy:</u></p> <p>70% of the total cost of the drug except emergency prescription purchases, which are covered at 100% less, the appropriate copayment as indicated above.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies used for cosmetic purposes</i> • <i>Vitamins and nutritional substances that can be purchased without a prescription, except for prenatal and pediatric vitamins</i> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i> • <i>The cost of a prescription drug when the usual and customary charge is less than the member’s prescription drug copayment</i> • <i>Medical supplies such as dressings and antiseptics</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Drugs to enhance athletic performance</i> • <i>Refills resulting from loss or theft, or any unauthorized refills</i> • <i>Nicotine patches or gum or any other pharmacological therapy for smoking cessation</i> • <i>Injectable fertility drugs</i> • <i>Pharmacological therapy for weight reduction or diet agents, except for treatment of Morbid Obesity</i> 	<i>All charges</i>	<i>All charges</i>

**Section 5(g)
Dental benefits**

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; 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 Description	You Pay	
	High Option	Standard Option
Accidental injury benefit		
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The services are covered if they are initiated within 6 months after the accident, or as other medical conditions permit, and are provided by participating Plan dentists. The need for these services must result from an accidental injury. Note: Pre-authorization is required.	\$25 copayment per visit.	\$40 copayment per visit. (No deductible)

Dental Benefits	You Pay	
	High Option	Standard Option
Service		
The following dental services are covered when provided by participating Plan general dentists: Preventive services: <ul style="list-style-type: none"> • Oral examination and diagnosis (limited to once in 6 months) • Prophylaxis/teeth cleaning to include scaling and polishing (limited to once in 6 months) • Topical fluoride (include child and adult) • Oral hygiene instruction Diagnosis services: <ul style="list-style-type: none"> • Complete series X-rays • Intraoral occlusal film • Bitewings (limited to once in 6 months) • Panoramic film • Cephalometric film Restorative services:	\$5 copayment per office visit	\$5 copayment per office visit

Service - continued on next page

High and Standard Option

Dental Benefits	You Pay	
Service (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Amalgam (silver) restoration to primary and permanent teeth • Anterior and posterior composite restoration to primary and permanent teeth • Pin retention <p>Sedative filling (per tooth)</p>	\$5 copayment per office visit	\$5 copayment per office visit
<p>Other services:</p> <ul style="list-style-type: none"> • Endodontic • Orthodontic • Oral surgery • Single unconnected crowns • Prosthodontic 	A discounted amount; what you pay may change periodically, so call us for the amounts you pay for these dental services.	A discounted amount; what you pay may change periodically, so call us for the amounts you pay for these dental services.
<p>Emergency dental services provided by participating and non-participating providers:</p> <p>We will provide coverage for covered dental services in connection with dental emergencies for palliative treatment (to relieve pain). To receive payment for these services from a non-participating dental provider, you must submit a receipt to Member Services. The receipt must be itemized and show the dental services performed and the charge for each service.</p> <ul style="list-style-type: none"> • Emergency exam • Palliative treatment of dental pain 	<p>\$5 copayment per office visit</p> <p>\$60 copayment per occurrence</p>	<p>\$5 copayment per office visit</p> <p>\$60 copayment per occurrence</p>
<i>Not covered: Other dental services not shown as covered</i>	<i>All charges</i>	<i>All charges.</i>

Section 5(h) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefit agreement that will include all terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period , but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	TDD #215-241-2018
Urgent care/travel benefit	<p>Ordinarily, you must get your care from providers who contract with us. As a Keystone Health Plan East member, you have access to urgent care through a nationwide network of Blue Cross[®] and Blue Shield[®] providers. Urgent care includes covered services provided in order to treat an unexpected illness or injury that is not life-threatening. The services must be required in order to prevent a serious deterioration in your or a covered family member’s health if treatment were delayed.</p> <p>If you become ill or injured while visiting outside the service area, call 1-800-810-BLUE to find names and addresses of nearby participating Blue Cross[®] and Blue Shield[®] Traditional (BlueCard providers). Before you obtain any urgent care, call Care Management Coordination at the phone number on our ID Card to have care preauthorized. An office visit copayment will be collected when the service is rendered. You will not need to file a claim.</p> <p>No coverage will be provided for urgent care that has not been preauthorized.</p>
Guest Membership	<p>Through our Guest Membership benefit, members who are away from home for at least 90 days may temporarily enroll in another Blue Cross and Blue Shield Network HMO. Members are also eligible for Guest Membership for up to six months if, for example, they are assigned out-of-area temporarily. Guest Membership enables members to receive the full range of HMO benefits and services offered by the hosting HMOs. To enroll, members simply contact their Guest Membership Coordinator in advance. The phone number is on the back of the ID card.</p> <p>Note: The Guest Membership Program requires a thirty day notification period before benefits are available.</p>

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 1-800-227-3115 or visit their website at www.ibx.com/fep.

Keystone Health Plan East also offers members these Distinct Health Enhancement Opportunities:

Weight Management Program— Keystone and Weight Watchers have a special offer for those who want to lose weight and keep it off! Keystone Members receive 100% reimbursement up to \$200 on Weight Watchers or a network hospital program of their choice.

Fitness Program— To give members added incentive to maintain an active lifestyle, we will reimburse members up to \$150 of their annual fitness club fees. Members can now enjoy the flexibility of joining any fitness club and working out at multiple fitness clubs. Visits can be recorded by computer printout, telephone or logbook. Members must complete 120 visits per 365-day enrollment period and maintain active coverage to receive reimbursement.

Smoking Cessation Program— If you smoke, quitting is one of the best things you can do for your health. Better yet, when you kick the habit, we'll help foot the bill! You can get up to \$200 back when you complete your choice of a variety of proven smoking cessation programs. And to give you more incentive, we now will reimburse you the costs of nicotine replacement products. If you choose a smoking cessation program that costs less than \$200, you can use the difference toward the purchase of nicotine replacement products, such as "the patch" or chewing gum.

CPR and First Aid Course Discounts— Keystone Health Plan East members will receive up to \$25 reimbursement for any course offered by the American Red Cross or American Heart Association.

Child Safety Program— Offers tips on how to reduce children's risk for household accidents such as burns, injuries from firearms, choking, and accidental poisonings, reimbursement up to \$25 for a bike helmet, tips for safe bicycling and more.

Alternative Health Discounted Services— Take advantage of up to a 30% discount from a national network of practitioners of acupuncture, massage therapy and dietetics. Also receive preferred discounts of up to 40% on more than 2,400 health and wellness products.

Baby BluePrints[®]— Our maternity program helps identify possible risk factors during pregnancy. It also offers educational materials and up to \$50 back for the cost of any approved childbirth class, and \$50 back toward the purchase of a breast pump.

ConnectionsSM Health Management Program— Access a Health Coach 24 hours a day, 7 days a week, 365 days per year. Receive educational materials and health reminders mailed to your home and utilize our on-line Healthwise[®] Knowledge base with thousands of articles on various health topics.

Preventive Health Reminders— Receive periodic reminders about important health screenings such as mammography, colorectal, PAP and osteoporosis.

For more information— Call the Health Resource Center 1-800-275-2583 or 215-241-3367 in the Philadelphia area.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusion 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. (See specifics regarding Transplants)**

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;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or 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 1-800-227-3114

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:

Keystone Health Plan East
PO Box 69353
Harrisburg, PA 17106-9353

• Prescription Drugs

Submit your claims to:

FutureScripts
Dept. # 0382
P.O. Box 419019
Kansas City, MO 64141

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.

- 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: ; 1901 Market Street, Philadelphia, PA 19103 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.

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OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-227-3114 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202-606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member 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 continue to be authorized by your Plan. We will not waive your copay.

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 probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-227-3115 or see our Website at www.ibx.com/fep.

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 plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: You may 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 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. 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 the program.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

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 16.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 16.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket cost (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
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 16
Experimental or investigational service	To establish if a biological product, medical device, drug or procedure is or is not experimental/investigational, a technology assessment is performed. The results of the assessment provide the basis for the determination of the service's status (e.g., medically effective, experimental, etc.). Technology assessment is the review and evaluation of available data from multiple sources using industry standard criteria to assess the medical effectiveness of the service. Sources of data used in technology assessment include, but are not limited to, clinical trials, position papers, articles published by local and/or nationally accepted medical organizations or peer-reviewed journals, information supplied by government agencies, as well as regional and national experts and/or panels and, if applicable, literature supplied by the manufacturer.
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:
Us/We	Us and We refer to Keystone Health Plan East.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/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;
- What happens when your enrollment ends; and
- When the next open season for enrollment begins.

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

Types of coverage available for you and your family

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

Children's Equity Act

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield 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 but 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 for 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 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 qualified 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 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)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking 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 provides comprehensive dental and vision insurance at competitive group rates with 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 crowns, 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.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

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).

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). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. 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.

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Summary of benefits for the High Option of Keystone Health Plan East - 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 copayment: \$20 primary care; \$25 specialist	18
Services provided by a hospital:		
• Inpatient	\$125 copayment per day up to \$625 maximum per admission (waived if readmitted within 90 days of discharge for same diagnosis)	33
• Outpatient	\$100 outpatient copayment for only Surgery in the Short Procedure Unit (SPU) or OutpatientHospital	34
Emergency benefits:		
• In-area	\$100 per emergency room visit; waived if admitted	37
• Out-of-area	\$100 per emergency room visit; waived if admitted	37
Mental health and substance abuse treatment:	Regular cost sharing	38
Prescription drugs:		
• Drugs prescribed by a licensed doctor and obtained at a Plan retail pharmacy		
• Formulary Generic Drugs	\$5 copayment per prescription or refill	41
• Formulary Brand Drugs	\$20 copayment per prescription or refill	41
• - Covered Non-formulary Drugs	\$50 copayment per prescription or refill	41
• A Mail Order program is available for maintenance medications	2 copayments per 90 day supply	41
• Non-Plan retail Pharmacy		
• - non-emergency	70% of the total cost of the drug	42
• Emergency	The appropriate copay indicated above	41

High Option Benefits	You pay	Page
Dental care:		
<ul style="list-style-type: none"> • Accidental injury benefit 	\$25 copayment per visit	43
<ul style="list-style-type: none"> • Preventive, Diagnostic, and Restorative dental care 	\$5 copayment per visit	43
Vision care:		
<ul style="list-style-type: none"> • One eye exam and refraction every two years 	\$25 copayment per visit	25
Special features: Services for deaf and hearing impaired, and Urgent care/travel benefit.		45
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after \$2,000/Self Only or \$4,000/Family enrollment per year Some costs do not count toward this protection.	16

Summary of benefits for the Standard Option of Keystone Health Plan East - 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.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$20 primary care; \$40 specialist	18
Services provided by a hospital:		
• Inpatient	20%, after deductible	33
• Outpatient	20%, after deductible for Surgery in Short Procedure Unit (SPU) or OutpatientHospital	34
Emergency benefits:		
• In-area	20%, after deductible (not waived if admitted)	37
• Out-of-area	20%, after deductible (not waived if admitted)	37
Mental health and substance abuse treatment:		
	Regular cost sharing	38
Prescription drugs:		
• Drugs prescribed by a licensed doctor and obtained at a Plan retail pharmacy		41
• Formulary Generic Drugs	\$20 copayment per prescription or refill	41
• Formulary Brand Drugs	\$40 copayment per prescription or refill	41
• - Covered Non-Formulary Drugs	\$60 copayment per prescription or refill	41
• A Mail Order program is available for maintenance medications	2 copayments per 90 day supply	41
• Non-Plan retail Pharmacy		
• Non-Emergency	70% of the total cost of the drug	41
• Emergency	The appropriate copayment indicated above	41
Dental care:		
• Accidental injury benefit	\$40 copayment per visit	43

Standard Option Benefits	You Pay	Page
<ul style="list-style-type: none"> Preventive, Diagnostic, and Restorative dental care 	\$5 copayment per visit	43
Vision care:		
<ul style="list-style-type: none"> One eye exam and refraction every two years 	\$40 copayment per visit	25
Special features: Services for deaf and hearing impaired, and Urgent care/travel benefit		45
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after \$3,000/Self Only or \$9,000/Family enrollment per year Some costs do not count toward this protection.	16

2009 Rate Information for Keystone Health Plan East

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

Postal rates apply to career Postal Service employees. Most employees should refer to the 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	ED1	\$155.66	\$103.63	\$337.26	\$224.54	\$179.45	\$79.84
High Option Self and Family	ED2	\$352.56	\$331.38	\$763.88	\$717.99	\$406.42	\$277.52
Standard Option Self Only	ED4	\$155.66	\$73.95	\$337.26	\$160.23	\$179.45	\$50.16
Standard Option Self and Family	ED5	\$352.56	\$253.45	\$763.88	\$549.14	\$406.42	\$199.59