2008

Keystone 65

A Blue Cross Medicare Advantage HMO Plan from Keystone Health Plan East

Keystone 65

Evidence of Coverage And Disclosure Information

Effective
January 1, 2008
through
December 31, 2008

Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties
H3952

Independence Blue Cross

IMPORTANT INFORMATION ABOUT KEYSTONE 65

The information in **At a Glance** will be useful when you use your benefits throughout the year. Take some time to review these pages — you may even find out something new about your health care coverage!

AT A GLANCE

Page Number

OTHER AREAS OF INTEREST

The sections below provide a brief overview of a few salient topics that your Evidence of Coverage addresses. This is a quick reference to issues that might concern you, such as how to receive medical care when you are traveling, and what services are covered under your plan. Please refer to the page numbers at the left to find the corresponding information section (with expanded details) in your Evidence of Coverage.

EVIDENCE OF COVERAGE

Page Number

21 How Do I Change My Primary Care Physician (PCP)?

To choose a new doctor, go to the provider directory to find a plan doctor, and then call Member Services to let us know of your decision. If you need help finding a provider in your area, call **1-800-ASK-BLUE**. Your PCP change will take effect on the first day of the following month. It's a good idea to schedule your first appointment with your new physician as soon as possible; don't wait until you're sick.

22 How Do I Get Care When I Travel?

Keystone 65 will cover the cost of urgent or emergency care you receive when you are outside the five-county service area but still within the United States. All you pay is the applicable copayment. If you have a medical emergency, go to the nearest emergency room or call 911 for assistance. An emergency is when you reasonably believe that your health is in serious danger — when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

Urgently needed care is covered if you need medical attention and must see a doctor right away. You can see a non-plan (out-of-network) doctor when you are out of the service area but still within the U.S., and in rare circumstances when you are within the service area but a plan (in-network) doctor is not available. As a Keystone 65 member, if you are traveling outside of the United States, you can only get coverage in a medical emergency under limited circumstances* defined by Medicare.

*Please see the Definitions section for more information about "limited circumstances."

If you have coverage through your former employer, Health and Welfare Fund, or Association Group, your policy and procedures may differ. In some cases, benefits may vary. Consult your Schedule of Copayments and Limitations or a Member Services Representative for additional information.

30 What Services are Covered?

This section lists all covered services that comprise your Keystone 65 benefits. "Covered services" include medical care, services, supplies, and equipment that are paid for by Keystone 65. For a complete list of covered services, consult your Evidence of Coverage Benefits Chart Section 3.

53 What Services are Not Covered?

Medical care and services that are not covered (sometimes called "excluded services" or "exclusions") are services that are not covered under any conditions and some services that are covered only under specific conditions. Also, please note that Keystone 65 will not pay for any service that is not provided by or referral by a plan (in-network) provider. Exceptions to this include emergency services and urgently needed care within the United States (and, under limited circumstances, emergency services outside the United States). See Section 4 for a complete list of exclusions and limitations.

55 How Do I File an Appeal or Grievance?

You can file an appeal with Keystone 65 if you believe that your plan failed to provide or pay for services that you think should have been covered. For more details, please refer to Section 8 of your Evidence of Coverage.

You can file a grievance with Keystone 65 about problems you encountered with one of our providers. You may also file a grievance about problems you experience with Keystone 65. We encourage you to let us know if you have concerns; we have Member Services representatives who are available to help you with your questions. Call us at the number listed on the back of your ID card. Or, to file a grievance, review the procedures in Section 7 of your Evidence of Coverage.

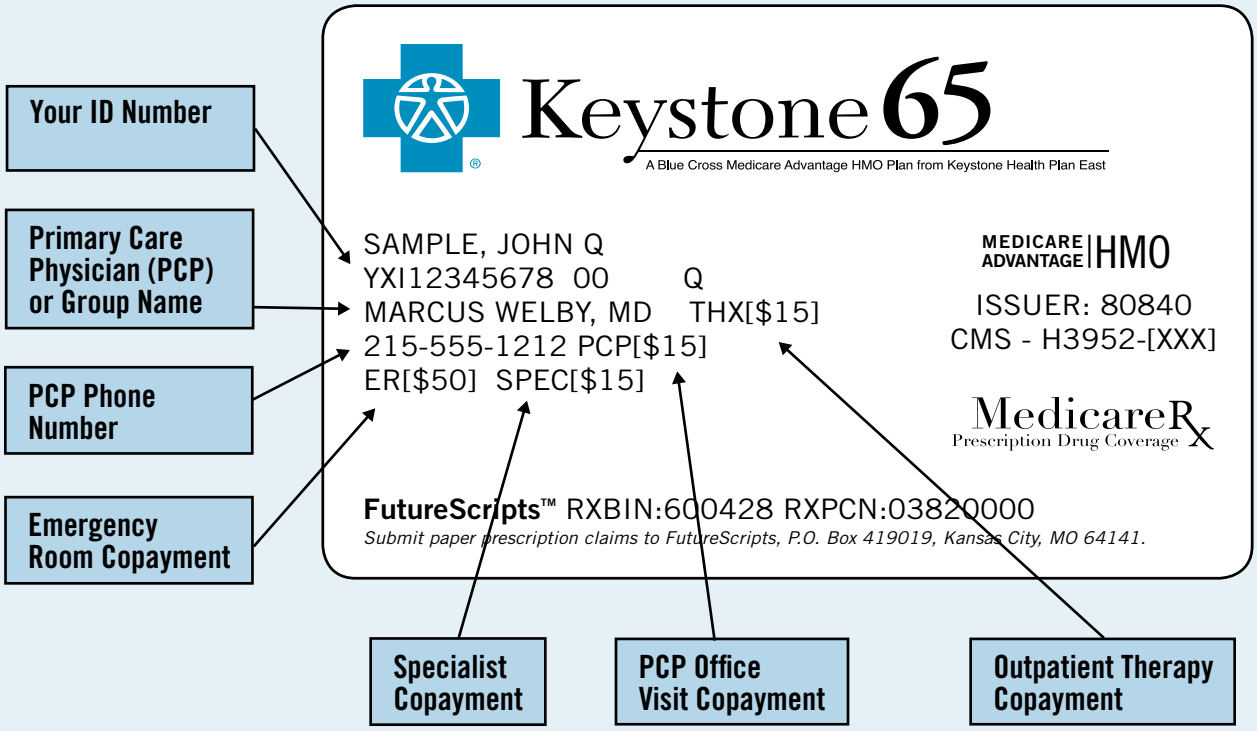
76 Definitions

This section explains some of the terms used in this booklet and in the Evidence of Coverage. Health care can be confusing — we hope these definitions help you to understand your coverage with Keystone 65.

YOUR ID CARD

Your Keystone 65 ID card has important information about your health care coverage; you should check your card to make sure the information is correct. On the reverse side of the card, you'll find instructions on how to receive emergency or urgent care if you are out of the Keystone 65 service area, as well as how to contact Member Services. Additionally, your ID card gives you important contact information for hospital admissions and instructions for using your primary care physician for your care. You should carry your card with you at all times, and remember to show it at your physician's office when you have an appointment. Call Keystone 65 Member Services if you lose your ID card or if anything on the card is incorrect. The following illustration should help you understand the components of your ID card.

KEYSTONE 65 ID CARD SAMPLE



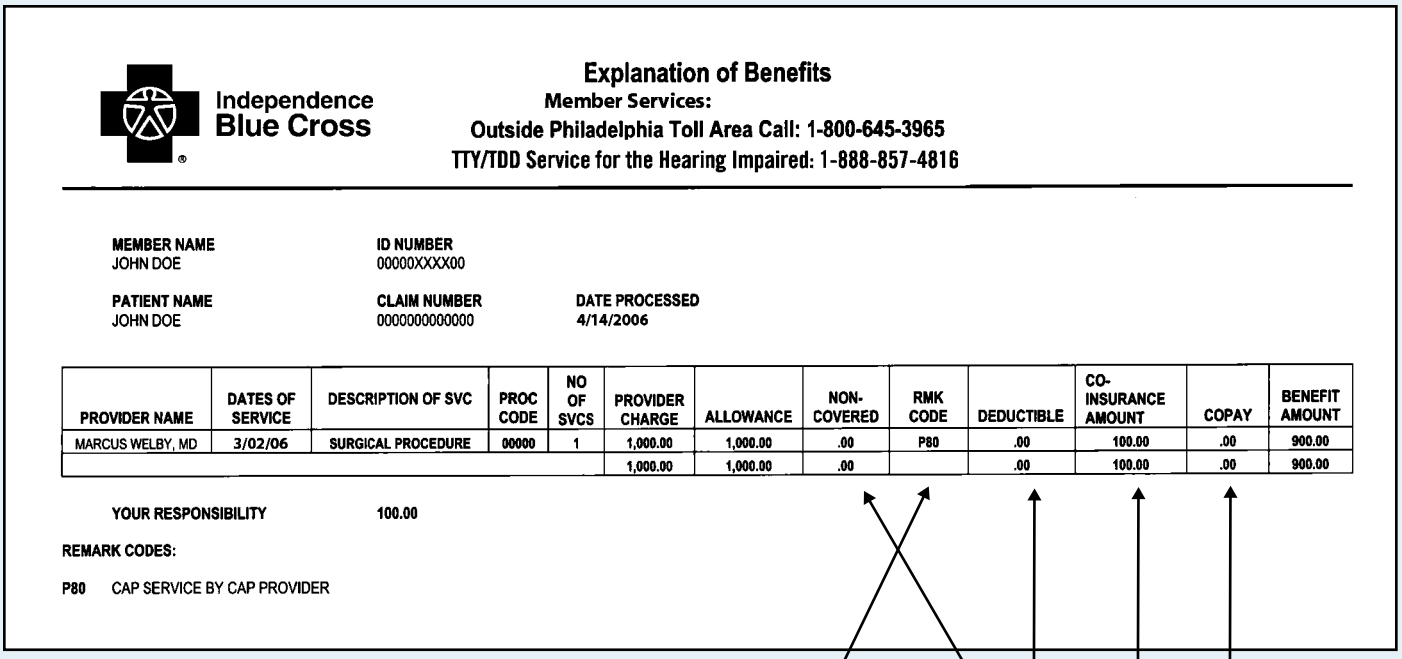
Member: Present this card to providers when seeking care. Contact your Primary Care Physician first for routine medical care. Specialist or hospital care services must be referred by your Primary Care Physician on a KHPE Referral Form, or you assume payment responsibility. See your Evidence of Coverage for details. Medicare charge limitations may apply.

Member Services:	**1-800-645-3965**
Mental Health/Substance Abuse:	**1-800-688-1911**
TTY/TDD:	**1-888-857-4816**

Urgent Care In Area: Call your PCP prior to receiving services.
Urgent Care Out of Area: Call 1-800-313-8564 for assistance in accessing out of area urgent care or you may seek care with another provider within the U.S.
Submit paper medical claims to:
P.O. Box 890016, Camp Hill, PA 17089-0016
In case of emergency, seek appropriate medical care immediately. Contact your PCP for follow-up care within 48 hours.
Hospital: Must call 1-800-227-3116 for admission notification within 24 hours.
Keystone 65
P.O. Box 7799
Philadelphia, PA 19101-7799
Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross, independent licensees of the Blue Cross and Blue Shield Association.
For benefits information, visit our Web site at **www.site65.com** 2201 (10/05)

YOUR MEDICAL EXPLANATION OF BENEFITS (EOB)

The Explanation of Benefits shows what services you have received and when you received them. It also lists the name of the provider who performed the service and what he or she charged. In addition, the Explanation of Benefits will indicate if there is any portion of the bill that you are required to pay. Please review your Explanation of Benefits to make sure you received the services that you were billed for.



Independence Blue Cross

Explanation of Benefits
Member Services:
Outside Philadelphia Toll Area Call: 1-800-645-3965
TTY/TDD Service for the Hearing Impaired: 1-888-857-4816

MEMBER NAME
JOHN DOE

ID NUMBER
00000XXXX00

PATIENT NAME
JOHN DOE

CLAIM NUMBER
0000000000000

DATE PROCESSED
4/14/2006

PROVIDER NAME	DATES OF SERVICE	DESCRIPTION OF SVC	PROC CODE	NO OF SVCS	PROVIDER CHARGE	ALLOWANCE	NON-COVERED	RMK CODE	DEDUCTIBLE	CO-INSURANCE AMOUNT	COPAY	BENEFIT AMOUNT
MARCUS WELBY, MD	3/02/06	SURGICAL PROCEDURE	00000	1	1,000.00	1,000.00	.00	P80	.00	100.00	.00	900.00
					1,000.00	1,000.00	.00		.00	100.00	.00	900.00

YOUR RESPONSIBILITY 100.00

REMARK CODES:

P80 CAP SERVICE BY CAP PROVIDER

Remark Code Descriptions

Member's Responsibility

Any questions? Call the Member Services Department at 1-800-645-3965 (TTY/TDD: 1-888-857-4816), seven days a week, from 8 a.m. to 8 p.m.

If applicable, there will be a separate page describing the Remark Code included with your EOB statement descriptions.

Please note that you are responsible to pay any amounts noted in the copay, coinsurance, deductible and non-covered columns.

Question: What happens to my health care coverage with Keystone 65 if I want to join a Medicare stand-alone prescription drug plan (PDP)?

Answer: Medicare regulations require that a Medicare beneficiary may not be enrolled in a Medicare Advantage plan (such as Keystone 65) and a prescription drug plan at the same time. Therefore, if you choose to enroll in a stand-alone prescription drug plan, Medicare requires us to disenroll you from Keystone 65. As your health care insurer, we urge you to be aware of this regulation and to call Member Services at **1-800-645-3965 (TTY/TDD: 1-888-857-4816)** 7 days a week, from 8 a.m. to 8 p.m., if you have questions or concerns.

Question: What drugs are covered under Part B (your Medical benefit), and what drugs are covered under Part D?

Answer: This can be confusing for our Medicare beneficiaries, and we want to keep this distinction as simple and straightforward as possible. The following are covered under Part D: prescription drugs, biological products, most vaccines, insulin, and the medical supplies that are associated with the injection of insulin (e.g., syringes, needles, alcohol swabs, and gauze). Smoking cessation agents are also covered under Part D.

Drugs that are covered under Part B include:

- Hemophilia factor drugs usually not self-administered by the patient and that are injected while receiving physician services.
- Drugs taken using durable medical equipment (e.g., nebulizers).
- Immunosuppressive drugs (if the member had an organ transplant covered by Medicare).
- Injectable osteoporosis drugs (if the member is homebound and cannot self-administer).
- Antigens.
- Oral cancer drugs (for which there is an IV equivalent).
- Intravenous immune globulin (IVIG).
- Certain drugs for dialysis, including heparin, Epogen® (epoetin alfa), erythropoietin (EPO), and Aranesp® (darboetin alfa).

Also, please be aware that the Centers for Medicare & Medicaid Services (CMS) require that some drugs can be covered under Part B or Part D, depending on the diagnosis or place of service. For example, the hepatitis B vaccine is covered under Part B if the member is at "high or intermediate risk;" Part D covers all other instances.

Please call Member Services at **1-800-645-3965 (TTY/TDD: 1-888-857-4816)** seven days a week, from 8 a.m. to 8 p.m., if you have questions about your drug coverage under Medicare Part D.

Question: My ID card lists my doctor's office name, not his or her individual name. Do I still see the same doctor?

Answer: Yes, you still see the same doctor. If you receive a new ID card and your doctor practices with a group of doctors in an office, the group name will be on your card instead of the individual doctor's name. You may, however, still see the same doctor as before.

RADIOLOGY QUALITY INITIATIVE PROGRAM (RQI)

Effective January 1, 2006, Independence Blue Cross implemented a **R**adiology **Q**uality **I**nitiative for outpatient diagnostic imaging services. Our decision to introduce this initiative was consistent with a recommendation from the American College of Radiology. This organization concluded that there is an immediate need for "nationally accepted, scientifically based appropriateness criteria" to guide radiologists and referring physicians in "making appropriate imaging decisions."

Over the last few years, health plans throughout the U.S. and many in the Philadelphia area have introduced prior authorization programs for diagnostic imaging as a way to promote appropriate utilization based on evidence-based criteria. Like other programs across the country, our Radiology Quality Initiative program requires prior authorization (approval in advance) for certain diagnostic imaging services:

- Computed Tomography (e.g. CT/CTA).
- Magnetic Resonance Imaging (e.g. MRI/MRA).
- Nuclear Cardiology Studies.
- Positron Emission Tomography (e.g. PET).

If you need one of these outpatient diagnostic imaging services in-network, your Keystone 65 plan (in-network) physician will handle the prior authorization process. This program does not apply to imaging services provided during emergency room visits or inpatient admissions. Keystone 65 has communicated the specifics of this program to our network physicians who are required to contact American Imaging Management, Inc. (AIM) for requests from network physicians for prior authorization of scheduled services listed above.

Please note: The guidelines used in the Radiology Quality Initiative program to assess the appropriateness of diagnostic imaging services are based on recommendations from experts in radiology and medicine. The program is aimed at curbing the use of discretionary scans for diagnostic screening. It is not intended to interfere with scans that are essential in the treatment of critical or life-threatening illnesses.

HEALTHY LIFESTYLES℠

Since you're a member of Keystone 65, why not take advantage of the services we offer through our Healthy Lifestyles programs? These programs can help you make positive changes to your life.

SilverSneakers®*

Independence Blue Cross is introducing a new fitness program to our Keystone 65 members. This new program will give Medicare members access to the SilverSneakers® Fitness Program, which is the nation's leading fitness program designed exclusively for Medicare eligibles. Membership to SilverSneakers is free and is provided to members at no additional cost beyond their monthly premium. Members apply to receive a basic fitness membership with access to amenities and fitness classes including the signature SilverSneakers classes designed to improve muscular strength, endurance, mobility, flexibility, range of motion, balance, agility, and coordination.

To locate a participating SilverSneakers gym, please visit them online at www.silversneakers.com or call our Member Services department at **1-800-645-3965 (TTY/TDD: 1-888-857-4816)**, seven days a week from 8 a.m. to 8 p.m.

Smoking Cessation*

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 you foot the bill up to $200. Members are encouraged to complete the smoking cessation program but not required.

Weight Management*

You will get up to $200 for the cost of Weight Watchers®[1] or any network hospital weight management program.

*These programs require enrollment.
[1] Weight Watchers® is a registered trademark of Weight Watchers International, Inc.

Mammography and Pap Test Screening

When it comes to breast cancer and cervical cancer, early detection is key. That's why we've sent nearly four million educational reminders to our female members that emphasize not only early detection but also prevention and treatment. You can also request personal reminders for these tests on our website.

STAY HEALTHY!

Care Management and Coordination

It can be difficult, and even intimidating, to find your way around the health care system. You might be scheduling elective surgery, such as a hip or knee replacement, or trying to manage complex home health care services. If that's the case, call on our staff of registered nurses to work with your health care provider and help coordinate your care.

Individual Support from the Connections℠ Health Management Program

If you have a condition such as diabetes, lung or breathing problems, heart conditions, or other recurring health concerns, our Connections program can help you lead a healthier life. Connections can also help if you're facing a significant medical decision such as treatment options for back or joint pain, breast or prostate cancer, or surgery, including weight-loss surgery.

Connections provides:

- Access to a Health Coach to talk to anytime, day or night, 24 hours a day, 7 days a week.
- Personalized check-in calls from your Health Coach about your chronic condition or other health concerns.
- Educational materials mailed to your home.
- Health reminders about important tests and information to help you take better control of your health.
- Access to an encyclopedia of health information — our Healthwise® Knowledgebase gives you well-organized health information on the Web, on audiotape, or through the mail in collaboration with your Health Coach.

We offer Connections for free. The program can help you work with your health care provider and get the support you need to manage your health. Call a Connections Health Coach anytime, day or night, 24 hours a day, 7 days a week, at **1-800-ASK-BLUE,** and see how we can help you.

IMPORTANT KEYSTONE 65 TELEPHONE NUMBERS

Keystone 65 Member Services 1-800-645-3965 (TTY/TDD: 1-888-857-4816)

If you have questions about your coverage or premium bill, would like to make a change to your benefits, or need to update your address, call Member Services seven days a week, from 8 a.m. to 8 p.m.

Healthy Lifestyles℠ 1-800-ASK-BLUE (toll free: 1-800-275-2583; TTY/TDD: 1-888-857-4816)

Take advantage of Healthy Lifestyles programs like Weight Watchers®, or call Healthy Lifestyles for help with smoking cessation. Enroll in the Connections Health Management program if you have a condition such as diabetes, lung or breathing problems, heart conditions, or other recurring health concerns. You can reach Healthy Lifestyles Monday – Friday, 8 a.m. to 6 p.m.

Medicare Savings Programs 1-877-393-6733

There are state and federally funded assistance programs for which certain members may qualify. To see if you are eligible for these programs, call Managed Care Programs at the number listed above Monday – Friday, from 8:30 a.m. to 5 p.m.

EVIDENCE OF COVERAGE:

January 1 – December 31, 2008

Your Medicare Health Benefits and Services as a Member of Keystone 65

This booklet gives the details about your Medicare health coverage and explains how to get the health care you need. This booklet is an important legal document. Please keep it in a safe place.

Keystone 65 Member Services:

For help or information, please call Member Services or go to our plan website at **wwwsite65.com**.

1-800-645-3965 (Calls to these numbers are free)

TTY/TDD users call: 1-888-857-4816

Hours of Operation: seven days a week, 8 a.m. to 8 p.m.

Welcome to Keystone 65!

We are pleased that you've chosen our plan.

Keystone 65 is a Health Maintenance Organization (an HMO) for people with Medicare.

Thank you for your membership in Keystone 65; you are getting your health care coverage through our plan. Keystone 65 is not a "Medigap" Medicare Supplement Insurance policy.

Throughout the remainder of this Evidence of Coverage, we refer to Keystone 65 as "plan" or "our plan."

This Evidence of Coverage explains how to get your health care coverage through our plan.

This Evidence of Coverage, together with your enrollment form, riders (including optional supplemental benefit brochures); Annual Notice of Change (ANOC); formulary, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of our plan. The information in this Evidence of Coverage is in effect for the time period from January 1, 2008 through December 31, 2008.

You are still covered by Medicare, but you are getting your Medicare services as a member of our plan.

This Evidence of Coverage will explain to you:

- What is covered by our plan and what isn't covered.
- How to get the care you need or your prescriptions filled including some rules you must follow.
- What you will have to pay for your health care or prescriptions.
- What to do if you are unhappy about something related to getting your covered services or prescriptions filled.
- How to leave our plan.

If you need this Evidence of Coverage in a different format (such as in Spanish, Braille, or audio tapes), please call us so we can send you a copy.

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Section 1 – Introduction

CONTACT INFORMATION

TELEPHONE NUMBERS AND OTHER INFORMATION FOR REFERENCE

HOW TO CONTACT OUR PLAN MEMBER SERVICES

If you have any questions or concerns, please call or write to our plan Member Services. We will be happy to help you.

CALL **1-800-645-3965**. This number is also on the cover of this booklet for easy reference. Our business hours are seven days a week, 8 a.m. to 8 p.m. Calls to this number are free.

TTY/TDD **1-888-857-4816**. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Our business hours are seven days a week, 8 a.m. to 8 p.m. Calls to this number are free.

WRITE Keystone 65 Member Services
P.O. Box 7799
Philadelphia, PA 19101-7799

VISIT 1901 Market Street
1st Floor
Philadelphia, PA 19103
8:30 a.m. to 4:30 p.m., Monday through Friday

WEBSITE **www.site65.com**

CONTACT INFORMATION FOR GRIEVANCES, ORGANIZATION DETERMINATIONS, COVERAGE DETERMINATIONS, AND APPEALS

PART C ORGANIZATION DETERMINATIONS

CALL **1-800-227-3116**. Our business hours are Monday to Friday, 8 a.m. to 6 p.m. Calls to this number are free.

TTY/TDD **1-888-857-4816**. This number requires special telephone equipment. Calls to this number are free.

WRITE Independence Blue Cross
Clinical Precertification
1901 Market Street
30th Floor
Philadelphia, PA 19103

PART C AND D GRIEVANCES, APPEALS, AND COVERAGE DETERMINATIONS

CALL **1-800-645-3965**. Our business hours are seven days a week, 8 a.m. to 8 p.m.
Calls to this number are free.

TTY/TDD **1-888-857-4816**. This number requires special telephone equipment.
Calls to this number are free.

FAX **1-888-289-3029**

WRITE Medicare Members Appeals Unit
PO Box 13652
Philadelphia, PA 19101-3652

SHIP – A STATE PROGRAM THAT GIVES FREE LOCAL HEALTH INSURANCE COUNSELING TO PEOPLE WITH MEDICARE

"SHIP," **S**tate **H**ealth **I**nsurance Assistance **P**rogram, is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, Medicare Cost Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan. This also includes special Medigap rights for people who have tried a Medicare Advantage Plan for the first time. Section 2 has more information about your Medigap guaranteed issue rights.

You may contact the SHIP in your state at:

Apprise
State Health Insurance Assistance Program
PA Department of Aging
555 Walnut Street, 5th Floor
Harrisburg, PA 17101
Phone: 1-800-783-7067.

You may also find the website for your local SHIP at **www.medicare.gov** on the Web. Under "Search Tools," select "Helpful Phone Numbers and Websites."

QUALITY IMPROVEMENT ORGANIZATION – A GROUP OF DOCTORS AND HEALTH PROFESSIONALS IN YOUR STATE THAT REVIEWS MEDICAL CARE AND HANDLES CERTAIN TYPES OF COMPLAINTS FROM PATIENTS WITH MEDICARE

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Section 8 for more information about complaints, appeals and grievances.

You may contact the QIO in your state at:

Quality Insights of Pennsylvania
2601 Market Place Street
Suite 320
Harrisburg, PA 17110
Phone: 1-800-322-1914

HOW TO CONTACT THE MEDICARE PROGRAM

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End-Stage Renal Disease or ESRD). The Centers for Medicare & Medicaid Services (CMS) is the federal agency in charge of the Medicare Program. CMS contracts with and regulates Medicare plans (including our plan). Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE (1-800-633-4227)** to ask questions or get free information booklets from Medicare. TTY users should call **1-877-486-2048**. Customer service representatives are available 24 hours a day, including weekends.
- Visit **www.medicare.gov**. This is the official government website for Medicare information. This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage plans and Medicare Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Web Sites." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer.

OTHER ORGANIZATIONS (INCLUDING SOCIAL SECURITY AND MEDICAID, A STATE GOVERNMENT AGENCY THAT HANDLES HEALTH CARE PROGRAMS FOR PEOPLE WITH LIMITED RESOURCES)

Medicaid helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact:

Department of Public Welfare
Office of Medical Assistance
P.O. Box 2675
Harrisburg, PA 17105-2675
Phone: 1-800-692-7462

SOCIAL SECURITY

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**. You may also visit **www.ssa.gov** on the Web.

RAILROAD RETIREMENT BOARD

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or **1-800-808-0772**. TTY users should call **312-751-4701**. You may also visit **www.rrp.gov** on the Web.

EMPLOYER (OR "GROUP") COVERAGE

If you or your spouse get your benefits from your current or former employer or union, or from your spouse's current or former employer or union, call your employer's or union's benefits administrator or Member Services if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. **Important Note:** You (or your spouse's) employer/union benefits may change, or you or your spouse may lose the benefits, if you or your spouse enrolls in Medicare Part D. Call your employer's or union's benefits administrator or Member Services to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

REPORT FRAUD, WASTE AND ABUSE

Health care fraud is a violation of state and/or federal law. The U.S. Chamber of Commerce estimates that three percent to ten percent of health care cost is attributed to fraud annually. The Corporate and Financial Investigations Department helps to protect members and providers from fraudulent and abusive practices. If you know of or suspect health insurance fraud, please report it. You are not required to provide identifying information about yourself when reporting fraud. Call the toll-free Fraud Hotline at **1-866-282-2707**.

ELIGIBILITY REQUIREMENTS

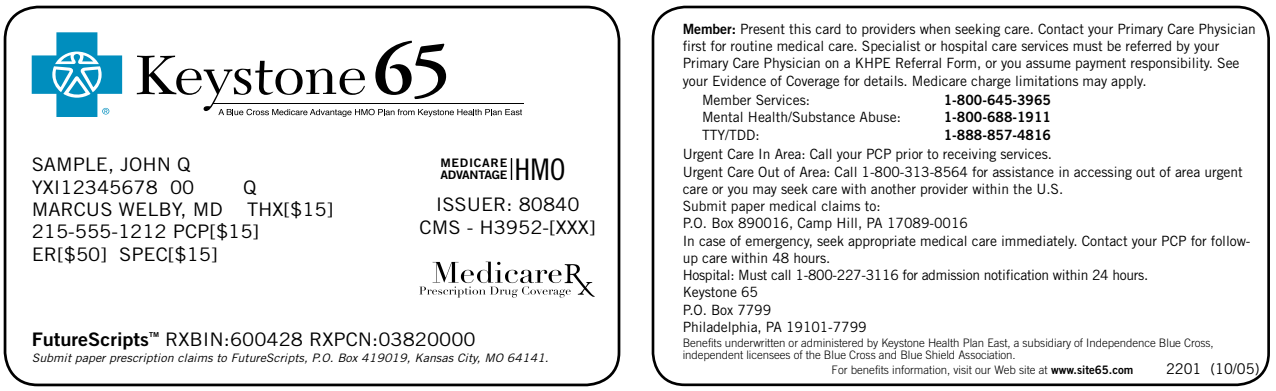
To be a member of our plan, you must live in our service area, be entitled to Medicare Part A, and be enrolled in Medicare Part B. If you currently pay a premium for Medicare Part A and Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

USE YOUR PLAN MEMBERSHIP CARD, NOT YOUR RED, WHITE, AND BLUE MEDICARE CARD

Now that you are a member of our plan, you must use our membership card for services covered by this plan and prescription drug coverage at network pharmacies. While you are a member of our plan and using our plan services, you *must* use your plan membership card instead of your red, white, and blue Medicare card to get covered services, items and drugs. (See Section 4 for information on Part D prescription coverage and Section 3 for information on covered services.) Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered services, items and drugs. If your membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Here is a sample card to show you what it looks like:



THE PROVIDER DIRECTORY GIVES YOU A LIST OF PLAN PROVIDERS

Except in emergencies, certain urgently needed services, and out-of-the-area dialysis services, you must use plan providers in order for services to be covered.

Every year, as long as you are a member of our plan, we will send you either a Provider Directory or an update to your Provider Directory, which gives you a list of our plan providers. If you don't have the Provider Directory, you can get a copy from Member Services. Contact information is located in Section 1 of this booklet. You may ask Member Services for more information about our plan providers, including their qualifications and experience.

HOW DO I KEEP MY MEMBERSHIP RECORD UP-TO-DATE?

We have a membership record about you as a plan member. Doctors, hospitals, pharmacists, and other plan providers use your membership record to know what services or drugs are covered for you. Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, the Primary Care Physician you chose when you enrolled, and other information. Section 5 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up-to-date by letting Member Services know right away if there are any changes to your name, address, or phone number or if you go into a nursing home. Also, tell Member Services about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, Workers' Compensation, Medicaid, or liability claims such as claims from an automobile accident. Call Member Services at the number in Section 1 of this booklet.

THE GEOGRAPHIC SERVICE AREA FOR OUR PLAN

You can enroll in Keystone 65 and get covered services as long as you live in the service area of: Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

Section 2 – How You Get Care

PROVIDERS YOU CAN USE TO GET SERVICES COVERED BY OUR PLAN

While you are a member of our plan, you must use our plan providers to get your covered services except in limited circumstances such as an emergency.

What are "plan providers"?

"Providers" is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services.

We call them "plan providers" when they participate in our plan. When we say that plan providers "participate in our plan," this means that we have arranged with them to coordinate or provide covered services to members in our plan.

What are covered services?

"Covered services" is the general term we use in this booklet to mean all the medical care, health care services, supplies, and equipment that are covered by our plan. Covered services are listed in the Benefits Chart in Section 3.

Rules about using non-plan providers to get your covered services

We list the providers that participate with our plan in our Provider Directory. These providers are called network providers. Except in limited cases such as emergency care, urgently needed care when our network is not available, or out-of-service-area dialysis, you must obtain covered services from network providers for the services to be covered. If you get non-emergency care from non-network providers without prior authorization from the plan, you must pay the entire cost yourself.

CHOOSING YOUR PRIMARY CARE PHYSICIAN (PCP)

What is a "PCP"?

When you become a member of Keystone 65, you must choose a plan physician to be your PCP. Your PCP is a physician who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. For example, in order to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist).

- Your X-rays.
- Laboratory tests.
- Therapies.
- Care from doctors who are specialists.
- Hospital admissions.
- Follow-up care.

"Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must a referral from your PCP. In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Section 5 tells you how we will protect the privacy of your medical records and personal health information.

How do you choose a PCP?

To select a PCP, you can refer to the Keystone 65 Provider Directory or call Member Services at the number listed on the cover of this booklet. Contact the Health Resource Center at **1-800-ASK-BLUE** to get a listing of providers in your area. You can also access our Provider Directory on Keystone 65's website at **www.site65.com.** If there is a particular Keystone 65 specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist or uses that hospital. The name and office telephone number of your PCP is printed on your membership card. We do not require you to pick a PCP who lives in your immediate neighborhood.

How do you get care from your PCP?

You will usually see your PCP first for most of your routine health care needs.

There are only a few types of covered services you may get on your own without contacting your PCP first, except as we explain below.

Besides providing much of your care, your PCP will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your X-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other plan (in-network) providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP will give you a referral. In some cases, your PCP will also need to get prior authorization (approval in advance) from Keystone 65. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your new PCP's office. Section 5 tells how we will protect the privacy of your medical records and personal health information. You should tell your PCP about other care or medications — due to continuity of care.

How do you get care from doctors, specialists, and hospitals?

When your PCP thinks that you need specialized treatment, he/she will give you a referral. A referral means that your PCP has given a written or electronic order approving you to see a plan specialist or to obtain services. A referral is issued in advance of seeing a plan specialist or in advance of obtaining services. A specialist is a doctor who provides health care services for a specific disease or part of the body. Specialists include but are not limited to such doctors as:

- Oncologists (who care for patients with cancer).
- Cardiologists (who care for patients with heart conditions).
- Orthopedists (who care for patients with certain bone, joint, or muscle conditions).

For some types of services, your PCP may need to get approval in advance from our plan (this is called getting "prior authorization").

It is very important to get a referral from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, including routine women's health care, that we explain later in this section). **If you don't have a referral before you get services from a specialist, you may have to pay for these services yourself.**

If the specialist wants you to come back for more care, check first to be sure that the referral you got from your PCP for the first visit covers more visits to the specialist.

If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. You may generally change your PCP at any time if you want to see a plan specialist that your current PCP can't refer you to. Later in this section, under "How can you switch to another PCP," we tell you how to change your PCP. If there are specific hospitals you want to use, you must first find out whether your PCP uses these hospitals.

How can you switch to another PCP?

You may change your PCP for any reason, at any time. To change your PCP, call Member Services. When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name and phone number of your new PCP.

What if your doctor or other provider leaves your plan?

Sometimes a PCP, specialist, clinic, hospital, or other plan provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of our plan. If your PCP leaves our plan, we will let you know and help you choose another PCP so that you can keep getting covered services.

What services can you get on your own, without getting a referral from your Primary Care Physician (PCP)?

You may get the following services on your own, without a referral from your PCP. You still have to pay your share of the cost, as appropriate, for these services:

- Routine women's health care, which include breast exams, mammograms (X-rays of the breast), Pap tests, and pelvic exams. This care is covered without a referral from a plan provider.
- Flu shots, influenza and pneumonia vaccinations, as long as you get them from a plan provider.
- Routine eye care (must be provided by Davis Vision plan (in-network) provider).
- Emergency services, whether you get these services from plan providers or non-plan providers.
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan's service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the plan providers are temporarily unavailable or inaccessible.
- Dialysis (kidney) services that you get when you are temporarily outside the plan's service area.
- Outpatient mental health care.

If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.

GETTING CARE WHEN YOU TRAVEL OR ARE AWAY FROM THE PLAN'S SERVICE AREA

If you need care when you are outside the service area, your coverage is limited (see definition of "limited circumstances"). The only services we cover when you are outside our service area, but within the United States, are care for a medical emergency, urgently needed care, renal dialysis, and care that Keystone 65 or a plan (in-network) provider has given you a referral. We do not provide coverage outside of the United States for a medical emergency (except under limited circumstances and as defined by Medicare) or for urgently needed care and renal dialysis. See below and Section 3 for more information about care for a medical emergency and urgently needed care. If you have questions about what medical care is covered when you travel, please call Member Services at the telephone number on the cover of this booklet.

GETTING CARE IF YOU HAVE A MEDICAL EMERGENCY OR AN URGENT NEED FOR CARE

What is a "medical emergency"?

A "medical emergency" is when you reasonably believe that your health is in serious danger — when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help, or go to the nearest emergency room, hospital, or urgent care center. **You don't need to get approval or a referral first from your PCP or other plan provider.**
- Make sure that we know about your emergency, because we need to be involved in following up on your emergency care. You or someone else should call to tell us about your emergency care as soon as possible, usually within 48 hours. The number to call is located on your Keystone 65 membership card.

We will help manage and follow up on your emergency care.

We will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, we will try to arrange for plan providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You may get covered emergency medical care whenever you need it, anywhere in the United States. See Section 2 for filling prescriptions when you cannot access a network pharmacy
- Emergency services received outside the United States are not covered except under limited circumstances (see definitions in Section 12) as defined by Medicare.

Ambulance services are covered in situations where other means of transportation in the United States would endanger your health.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care — thinking that your health is in serious danger — and the doctor may say that it wasn't a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong (as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency"). However, please note that:

- If you get any extra care after the doctor says it wasn't a medical emergency, the plan will pay its portion of the covered additional care **only if you get it from a plan provider.**
- If you get any extra care from a non-plan provider after the doctor says it wasn't a medical emergency, the plan will usually not cover the extra care. We will pay our portion of the covered additional care from a non-plan provider if you are out of our service area, as long as the additional care you get meets the definition of "urgently needed care" that is given below.

What is urgently needed care? (This is different from a medical emergency)

Urgently needed care refers to a non-emergency situation where you are inside the United States, you are temporarily absent from the plan's authorized service area, you need medical attention right away for an unforeseen illness, injury, or condition, and it isn't reasonable given the situation for you to obtain medical care through the plan's participating provider network. **Note**: Under unusual and extraordinary circumstances, care may be considered urgently needed when the member is in the service area, but the provider network of the plan is temporarily unavailable or inaccessible.

What is the difference between a "medical emergency" and "urgently needed care"?

The two main differences between urgently needed care and a medical emergency are in the danger to your health and your location. A "medical emergency" occurs when you reasonably believe that your health is in serious danger, whether you are in or outside of the service area. "Urgently needed care" is when you need medical help for an unforeseen illness, injury, or condition, but your health is not in serious danger and you are generally outside of the service area.

How to get urgently needed care

If, while temporarily outside the plan's service area, you require urgently needed care, then you may get this care from any provider. The plan is obligated to cover all urgently needed care at the cost-sharing levels that apply to care received within the plan network.

Note: If you have a pressing, non-emergency medical need while in the service area, you generally must obtain services from the plan according to its procedures and requirements as outlined in other sections of this document.

HOSPITAL CARE, SKILLED NURSING FACILITY CARE, AND OTHER SERVICES

How do you get hospital care?

If you need hospital care, we will cover these services for you. Covered services are listed in the Benefits Chart in Section 3 under the heading "Inpatient Hospital Care."

We use "hospital" to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

What happens if you join or leave our plan during a hospital stay?

If you either join or leave our plan during an inpatient hospital stay, special rules may apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services. Member Services can explain how your services are covered for this stay and what you owe to providers, if anything, for the periods of your stay when you were and were not a plan member.

What is skilled nursing facility care?

"**S**killed **N**ursing **F**acility care" means a level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals when the needs of a member requires a professional nurse or therapist and the service can only be provided on an impatient basis, e.g., physical therapy and occupational therapy 5 times a week for one hour or more. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

How do you get skilled nursing facility care (SNF care)?

If you need skilled nursing facility care, we will cover these services for you based on medical necessity. Covered services are listed in the Benefits Chart in Section 3 under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your covered services.

Are nursing home stays that provide custodial care covered?

"Custodial care" is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. We don't cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

What are the benefit period limitations on coverage of skilled nursing facility care?

Coverage for inpatient skilled nursing facility care is limited to a certain amount of days per benefit period. Please refer to the Schedule of Copayments and Limitations applicable to your current coverage for the number of covered inpatient SNF days per benefit period. A **"benefit period"** begins on the first day you go to a Medicare-covered SNF or hospital and ends when you have not received any SNF or hospital care for 60 days in a row. **If you go to the SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.**

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Section 3 under the heading "Inpatient services (when the SNF days are not or are no longer covered)."

What are the situations when you may be able to get care in a skilled nursing facility (SNF) that isn't a plan provider?

Generally, you will get your skilled nursing facility care from plan SNFs. However, under certain conditions shown below, you may be able to pay in-network cost-sharing for skilled nursing facility care from a SNF that isn't a plan provider if the SNF accepts our plan's amounts for payment:

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

Keystone 65 cannot assure the quality of services that members will receive from a skilled nursing facility that is not a plan (in-network) provider.

What happens if our plan doesn't authorize your care?

Except in cases of medical emergencies, you or your provider must obtain prior authorization for your SNF stay. The plan will offer alternate settings such as: home with home care services, Assisted Living Facility, or staying at the SNF at custodial level of care. At this level of care, you will be financially responsible.

What happens if you join or leave our plan during a skilled nursing facility (SNF) stay?

If you either join or leave our plan during a SNF stay, please call Member Services. Member Services can explain how your services are covered for this stay, and what you owe, if anything, for the periods of your stay when you were and weren't a plan member.

How do you get home health care?

Home health care is ordered by your physician when you need skilled care in you home for an illness or injury. Skilled care includes nursing care, physical therapy, occupational therapy, speech therapy, a social worker, and a dietician. Covered services are listed in the Benefits Chart in Section 3 under the heading "Home health care." If you need home health care services, we will cover these services for you provided the Medicare coverage requirements are met.

What are the requirements for getting home health agency services?

To get home health/agency care benefits, you must meet all of these conditions:

1. You must be **homebound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.
    - Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.
    - Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. "Supportive devices" include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.
2. Your doctor must decide that you need medical care in your home and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.
3. The home health agency caring for you must be approved by the Medicare program.
4. **You must need at least one of the following types of skilled care:**
    - Skilled nursing care on an "intermittent" (not full-time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
    - Physical therapy, which includes exercise to regain the movement and strength of an area of the body, and training on how to use special equipment or do daily activities, such as how to use a walker or get in and out of a wheelchair or bathtub.
    - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
    - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

When can home health care include services from a home health aide?

As long as some qualifying skilled-nursing services are also included, the home health care you get can include services from a home health aide. A home health aide doesn't have a nursing license or provide therapy. The home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). The services from a home health aide must be part of the home care of plan for your illness or injury, and they aren't covered unless you are also getting a covered skilled nursing service. "Home health services" don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

What are "part-time" and "intermittent" home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for "part-time" or "intermittent" skilled nursing services and home health aide services:

- **"Part-time"** or **"intermittent"** means your skilled nursing and home health aide services combined total less than eight hours per day and 35 or fewer hours each week.

What is hospice care?

"Hospice" is a special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients who qualify for hospice care in the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

How do you get hospice care if you are terminally ill?

As a member of our plan, you may receive care from any Medicare-certified hospice program. Your doctor can help you arrange hospice care. If you are interested in using hospice services, you may call Member Services to get a list of the Medicare-certified hospice providers in your area, or you may call the Regional Home Health Intermediary at **1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048**. (If you are enrolled in Medicare Part B only and not entitled to Part A, you should call Member Services to get information on your hospice coverage.)

How is your hospice care paid for?

If you enroll in a Medicare-certified hospice program, the Original Medicare Plan (rather than our plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a plan provider or a non-plan provider. Even if you choose to enroll in a Medicare-certified hospice, you will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our plan.

How to get more information on hospice care

Visit **www.medicare.gov** on the Web. Under "Search Tools," select "Find a Medicare Publication" to view or download the publication *Medicare Hospice Benefits*. Or, call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

How to get an organ transplant if you need it

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others aren't). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. The following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

How can you participate in a clinical trial?

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our plan) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our plan and continue to get the rest of your care that is unrelated to the clinical trial through our plan.

You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive when participating in a qualifying clinical trial. You do not have to pay the Original Medicare Part A or Part B deductibles, because you are enrolled in our plan. For instance, you will be responsible for Part B coinsurance — generally, 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no coinsurance for Medicare-covered clinical laboratory services related to the clinical trial. The Medicare program has written a booklet that includes information on Original Medicare coinsurance rules, called *Medicare & You*. To get a free copy, call **1-800-MEDICARE (1-800-633-4227)** or visit **www.medicare.gov** on the Web.

You will have to pay the Original Medicare coinsurance or copayments that apply to clinical trial services. The Medicare program has written a booklet called *Medicare and Clinical Trials*. To get a free copy, call **1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048)** or visit **www.medicare.gov** on the Web. Section 1 tells more about how to contact the Medicare program and about Medicare's website.

You don't need to get a referral (approval in advance) from a plan provider to join a clinical trial, and the clinical trial providers don't need to be plan providers. However, please be sure to **tell us before you start participation in a clinical trial** so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know what services you will get from clinical trial providers and the cost for those services. You may view or download the publication *Medicare and Clinical Trials* at **www.medicare.gov** on the Web. Under "Search Tools," select "Find a Medicare Publication." Or, call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

HOW TO ACCESS CARE IN RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS

Care in a Medicare-certified **R**eligious **N**on-medical **H**ealth **C**are **I**nstitution (RNHCI) is covered by our plan under certain conditions. Covered services in an RNHCI are limited to non-religious aspects of care. To be eligible for covered services in an RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when furnished in the home but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state, or local law. "Non-excepted" medical treatment is any other medical care or treatment.) You must also get prior authorization (approval in advance) from Keystone 65, or your stay in the RNHCI may not be covered.

NON-EMERGENCY AMBULANCE TRANSPORT

Non-emergency ambulance services are covered if they meet medical necessity and origin/destination requirements.

What are the requirements for getting nonemergency ambulance transport?

- **Medical necessity requirements.** Nonemergency transportation by ambulance is covered if you are bed-confined, and it is documented that other methods of transportation would be dangerous to your condition; or if your medical condition, whether or not you are bed-confined, necessitates transportation by ambulance.
- **Origin/destination requirements.** We cover the following nonemergency ambulance transport:

  (1) From any point of origin to the nearest hospital, critical access hospital (CAH), or skilled nursing facility (SNF) that is capable of furnishing the required level and type of care for your illness or injury.

  (2) From a hospital, CAH, or SNF to your home.

  (3) From a SNF to the nearest supplier of medically necessary services not available at the SNF where you are receiving skilled services, including the return trip.

  (4) From your home to the nearest facility that furnishes renal dialysis, including the return trip, if you are receiving renal dialysis for treatment of ESRD.

Section 3 – Covered Benefits

What are "covered services"?

This section describes the medical benefits and coverage you get as a member of our plan. **"Covered services" means the medical care, services, supplies, and equipment that are covered by our plan.** This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. Section 6 tells about **services that aren't covered** (these are called "exclusions"). Section 6, any applicable riders, supplemental benefits, or any amendments also tell about limitations on certain services.

THERE ARE SOME CONDITIONS THAT APPLY IN ORDER TO GET COVERED SERVICES

Some general requirements apply to all covered services

The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered. (See Section 12 for a definition of "medically necessary.")
- With few exceptions, covered services must be provided by plan providers, be referred by plan providers, and some services may need to be authorized by our plan.

In addition, some covered services require "prior authorization" by the plan in order to be covered. Some of the covered services listed in the Benefits Chart in this section are covered only if your doctor or other plan provider gets prior authorization (approval in advance) from our plan. Covered services that need prior authorization are marked in the Benefits Chart.

IMPORTANT NOTE: If you have coverage through your former employer, health and welfare fund, or association group, your policy and procedures may differ. In some cases, benefits may vary. Consult your Schedule of Copayments and Limitations or Member Services for additional information.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Inpatient Services	
Inpatient hospital care **Requires prior authorization (approval in advance) to be covered** For more information about inpatient hospital care, see Section 2. Covered services include, but aren't limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical therapy, occupational therapy, and speech therapy. • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. See Section 2 for more information about transplants. • Blood. • Physician services.	Please see the attached Schedule of Copayments and Limitations.
Inpatient mental health care **Requires prior authorization (approval in advance) to be covered** Covered services include mental health care services that require a hospital stay. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital.	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Skilled nursing facility care **Requires prior authorization (approval in advance) to be covered** For more information about skilled nursing facility care, see Section 2. Covered services include, but aren't limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (This includes substances that are naturally present in the body, such as blood clotting factors). • Blood. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services.	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Inpatient services (when the hospital* or SNF days aren't, or are no longer, covered) For more information about inpatient services, see Section 2. Covered services include, but aren't limited to, the following: • Physician services. • Tests (like X-ray or lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations. • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition. • Physical therapy, speech therapy, and occupational therapy. *Hospital stays are subject to benefit period limitations for Keystone 65 Complete members.	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Home health agency care **Requires prior authorization (approval in advance) to be covered** For more information about home health agency care, see Section 2. Covered services include, but aren't limited to, the following: • Part-time or intermittent skilled nursing and home health aide services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies.	Please see the attached Schedule of Copayments and Limitations.
Hospice care For more information about hospice services, see Section 2. Covered services include, but aren't limited to, the following: • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	**WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES**
Outpatient Services	
Physician services, including doctor office visits Covered services include, but aren't limited to, the following: • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a specialist. • Office visits for a second opinion prior to surgery. • Outpatient hospital services. • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor).	Please see the attached Schedule of Copayments and Limitations.
Chiropractic services Covered services include, but aren't limited to, the following: • Manual manipulation of the spine to correct subluxation.	Please see the attached Schedule of Copayments and Limitations.
Podiatry services Covered services include, but aren't limited to, the following: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Outpatient mental health care (including Partial Hospitalizaton Services) **Requires prior authorization (approval in advance) to be covered** Covered services include, but are not limited to, the following: • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. • "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	Please see the attached Schedule of Copayments and Limitations.
Outpatient substance abuse services **Requires prior authorization (approval in advance) to be covered.**	Please see the attached Schedule of Copayments and Limitations.
Outpatient surgery **Requires prior authorization (approval in advance) to be covered.** • Includes diagnostic/screening tests such as endoscopy and colonoscopy.	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Ambulance services • Ambulance services hospital-to-hospital and services dispatched through 911, where other means of transportation could endanger your health. • Ambulance services from a hospital to a SNF, only if you are bedbound or transportation in any other vehicle would endanger your health Requires prior authorization (approval in advance) to be covered. • Ambulance service from your home to a hospital or SNF, only if you are bedbound or transportation in any other vehicle could endanger your health. Requires prior authorization (approval in advance) to be covered. • Air ambulance only in emergency situations, as defined by Medicare. Requires prior authorization (approval in advance) to be covered.	Please see the attached Schedule of Copayments and Limitations.
Emergency care For more information, see Section 2. Not covered outside the United States except under limited circumstances (see definition in Section 12) as defined by Medicare.	Please see the attached Schedule of Copayments and Limitations.
Urgently needed care For more information, see Section 2. Not covered outside the United States.	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Outpatient rehabilitation services Covered services include, but aren't limited to, the following: physical therapy, occupational therapy, and speech and language therapy. • Physical therapy and occupational therapy. (Only requires prior authorization (approval in advance)* if not performed at the PCP's designated site. • Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris. Requires prior authorization (approval in advance) to be covered.* • Speech therapy and cardiac rehabilitation. Requires prior authorization (approval in advance) to be covered.*	Please see the attached Schedule of Copayments and Limitations.
Durable medical equipment and related supplies • All purchased items more than $500 require prior authorization (approval in advance) to be covered. • All rental items, regardless of price, require prior authorization (approval in advance) to be covered. • Oxygen is an exception and does not require prior authorization (approval in advance) to be covered. • Wheelchairs, crutches, hospital bed, IV infusion pump, insulin pump, oxygen equipment, nebulizer, and walker are covered. (See definition of "durable medical equipment" in Section 12.)	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Prosthetic devices and other supplies (other than dental) — that replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, breast prostheses (including a surgical brassiere after a mastectomy). • Surgical supplies, such as dressings. • Supplies such as splints and casts. • Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery — see "Vision Care" on page 45 for more detail. Requires prior authorization (approval in advance) to be covered.	Please see the attached Schedule of Copayments and Limitations.
Diabetes self-monitoring, training and supplies — for all people who have diabetes (insulin and non-insulin users). Covered services include, but aren't limited to, the following: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • One pair, per calendar year, of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. Self-management training is covered under certain conditions. For persons at risk of diabetes: Fasting plasma glucose tests.	Please see the attached Schedule of Copayments and Limitations.
Medical nutrition therapy For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Outpatient diagnostic tests and therapeutic services Covered services include, but are not limited to, the following: • X-rays and other radiology services. Certain services prior authorization (approval in advance) to be covered. • Radiation therapy. • Laboratory tests. • Blood. • Positron Emission Tomography (PET scan). Requires prior authorization (approval in advance) to be covered. • Ultrasounds. • Stress test. • Computed Tomography (e.g., CT/CTA). • Magnetic Resonance Imaging (e.g., MRI/MRA). • Nuclear Cardiology Studies.	Please see the attached Schedule of Copayments and Limitations.
Preventive Care and Screening Tests	
Bone-mass measurements For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	Please see the attached Schedule of Copayments and Limitations.
Immunizations Covered services include, but aren't limited to, the following: • Pneumonia vaccine. (As explained in Section 2, you may get this service on your own, without a referral from your PCP, as long as you get the service from a plan provider.) • Flu shots, once a year in the fall or winter. (As explained in Section 2, you may get this service on your own, without a referral from your PCP as long as you get the service from a plan provider.) • If you are at high or intermediate risk of getting hepatitis B: hepatitis B vaccine. • Other vaccines if you are at risk.	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Mammography screening (As explained in Section 2, you may get this service on your own, without a referral from your PCP, as long as you get it from a plan provider.) Covered services include, but aren't limited to, the following: • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	Please see the attached Schedule of Copayments and Limitations.
Pap tests, pelvic exams, and clinical breast exam You may get these routine women's health services on your own, without a referral from your PCP, as long as you get the services from a plan provider. Covered services include, but aren't limited to, the following: • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 12 months. • If you are at high risk of cervical cancer or have had an abnormal pap test and are of childbearing age: one Pap test every 12 months.	Please see the attached Schedule of Copayments and Limitations.
Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	Please see the attached Schedule of Copayments and Limitations.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).	Please see the attached Schedule of Copayments and Limitations.
Physical exams You are covered for one physical exam each calendar year.	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Other Services	
Dialysis (Kidney) Covered services include, but aren't limited to, the following: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 2 and 3). • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply).	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Prescription Drugs Covered under the original Medicare plan (these drugs are covered for everyone with Medicare). "Drugs" includes substances that are naturally present in the body, such as blood-clotting factors. Covered drugs include, but aren't limited to, the following: • Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan. **Note:** Nebsolutions are only covered under Part B when that patient lives at home. Part D covers Nebsolutions if they are in a long term care facility. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.	Please see the attached Schedule of Copayments and Limitations.

Benefits chart – your covered services	WHAT YOU MUST PAY WHEN YOU GET THESE COVERED SERVICES
Additional Benefits	
Dental services Services by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. Requires prior authorization (approval in advance) to be covered.	Please see the attached Schedule of Copayments and Limitations.
Hearing services • Diagnostic hearing exams. • Hearing aid reimbursement.	Please see the attached Schedule of Copayments and Limitations.
Vision care Covered services include, but aren't limited to, the following: • Outpatient physician services for eye care. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. • Refractive eye exams. • Routine eye exam (every two years). • Reimbursement for prescription lenses and frames every two years.	Please see the attached Vision Schedule of Copayments and Limitations.
Health and wellness education programs (i.e., Healthy Lifestyles℠, SilverSneakers®) Programs focused on clinical health conditions such as congestive heart failure and diabetes. Keystone 65 covers a variety of health education programs. For more information, please call Member Services at the number on the back cover of this booklet.	Please see the attached Schedule of Copayments and Limitations.

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services you believe are covered for you as a member, we want to help. Please call Member Services. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered as a member. See Section 8 for information about making a complaint.

Can your benefits change during the year?

Generally, your benefits will not change during the year. The Medicare Program doesn't allow us to decrease your benefits during the calendar year. The only time your benefits may decrease is at the beginning of the next calendar year. The Medicare Program must approve any decreases we make in your benefits. We will tell you in November if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1.

At any time during the year, the Medicare Program can change its national coverage. Since we cover what the Original Medicare Plan covers, we would have to make any change that the Medicare Program makes. If your benefits increase, the Original Medicare Plan will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay the Original Medicare Plan out-of-pocket amounts for those services. We will let you know in advance if you will have to pay the Original Medicare Plan out-of-pocket costs for an increased benefit.

Section 4 – What You Must Pay

Can your premiums change during the year?

Generally, your plan premium can't change during the calendar year. We will tell you in advance if there will be any changes for the next calendar year in your plan premiums or in the amounts you will have to pay when you get your prescriptions covered. If there are any changes for the next calendar year, they will take effect on January 1.

What happens if you don't pay your plan premiums, or don't pay them on time?

If your plan premiums are late, we will tell you in writing that if you don't pay your premium by the end of the 180-day grace period, we will end your membership in our plan. Should you decide later to re-enroll in our plan, or to enroll in another plan offered by our plan, you will have to pay any late plan premiums that you didn't pay from your previous enrollment in our plan.

PAYING YOUR SHARE OF THE COST WHEN YOU GET COVERED SERVICES

A **"cost-share"** is a payment you make for your share of the cost of certain covered services you receive. Examples include copayments, coinsurance, and deductibles. A cost-share is **a set amount per service**. The Schedule of Copayments and Limitations applicable to your current coverage gives your cost-shares for covered services.

What are "deductibles," "copayments," and "coinsurance"?

- The **"deductible"** is the amount you must pay for the health care services you receive before our plan begins to pay its share of your covered services.
- A **"copayment"** is a payment you make for your share of the cost of certain covered services you get. A copayment is a set amount per service (such as paying $10 for a doctor visit). You pay it when you get the service. The Schedule of Copayments and Limitations gives your copayments for covered services.
- **"Coinsurance"** is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is a percentage of the cost of the service (such as paying 20% for a doctor visit). You pay your coinsurance when you get the service. The Schedule of Copayments and Limitations gives your coinsurance for covered services.

What is your cost for services that aren't covered under our plan?

You are responsible to pay the full cost of care and services that aren't covered by our plan. Other sections of this booklet describe the services that are covered under our plan and the rules that apply to getting your care as a plan member.

If you have any questions about whether our plan will pay for a service or item, including inpatient hospital services, you have the right to have an organization determination or a coverage determination made for the service. You may call Member Services and tell us you would like a decision on whether the service will be covered.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service, unless your plan offers, as a covered supplemental benefit, coverage beyond the original Medicare limits. You can call Members Services when you want to know how much of your benefit limit you have already used.

USING ALL OF YOUR INSURANCE COVERAGE

If you have additional health insurance coverage besides our plan, it is important that you use your other coverage in combination with your coverage as a member of our plan to pay your health care expenses. This is called "coordination of benefits" because it involves coordinating all of the health drug benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

You are required to tell our plan if you have additional health insurance coverage

You must tell us if you have any other coverage besides our plan, and let us know whenever there are any changes in your additional coverage. The types of additional coverage you might have include the following:

- Coverage that you have from an employer's group health insurance for employees or retirees, either through yourself or your spouse.
- Coverage that you have under Workers' Compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the "TRICARE for Life" program (veteran's benefits).
- Coverage you have for dental insurance.
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

What should you do if you have bills from non-plan providers that you think we should pay?

As explained in Section 2, we cover certain health care services that you get from non-plan providers. These include care for a medical emergency, urgently needed care, renal dialysis that you get when you are outside the service area for our plan, care that has been approved in advance by a plan provider, and services that we denied but that were overturned in an appeal. If a non-plan provider asks you to pay for covered services you get in these situations, please contact us at:

Keystone 65
P.O. Box 890016
Camp Hill, PA 17089-0016

It is best to ask a non-plan provider to bill us first, but if you have already paid for the covered services, we will pay you for our share of the cost. If you get a bill for the services, you may send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You won't have to pay a non-plan provider any more than what they would have gotten from you if you had been covered under the Original Medicare Plan.

Section 5 – Your Rights and Responsibilities as a Member of Our Plan

INTRODUCTION TO YOUR RIGHTS AND PROTECTIONS

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our plan, and we explain what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, or visit **www.medicare.gov** on the Web to view or download the publication *Your Medicare Rights & Protections*. Under "Search Tools," select "find a Medicare Publication." If you have any questions whether our plan will pay for a service, including inpatient hospital services, and including services obtained from providers not affiliated with our plan, you have the right under law to have a written/binding advance coverage determination made for the service. Call us and tell us you would like a decision if the service or item will be covered.

YOUR RIGHT TO BE TREATED WITH DIGNITY, RESPECT AND FAIRNESS

You have the right to be treated with dignity, respect, and fairness at all times. Our plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Member Services at the phone number in Section 1. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at **1-800-368-1019** or **TTY/TDD 1-800-537-7697**, or your local Office for Civil Rights.

YOUR RIGHT TO THE PRIVACY OF YOUR MEDICAL RECORDS AND PERSONAL HEALTH INFORMATION

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at medical records held at the plan, and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services at the phone number in Section 1 of this booklet. The plan will release your information to Medicare, which may release it for research and other purposes that follow all applicable federal statutes and regulations.

YOUR RIGHT TO SEE PLAN PROVIDERS, GET COVERED SERVICES, AND GET YOUR PRESCRIPTIONS FILLED WITHIN A REASONABLE PERIOD OF TIME

As explained in this booklet, you will get most or all of your care from plan providers, that is, from doctors and other health providers who are part of our plan. You have the right to choose a plan provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get he care and services you need. You have the right to timely access to your prescriptions at any network pharmacy.

YOUR RIGHT TO KNOW YOUR TREATMENT OPTIONS AND PARTICIPATE IN DECISIONS ABOUT YOUR HEALTH CARE

You have the right to get full information from your providers when you go for medical care and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. Note: This includes the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination or a coverage determination. Organization determinations are discussed in Section 8.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

Note: This includes the right to know about the different Medication Management Treatment Programs we offer and in which you may participate.

YOUR RIGHT TO USE ADVANCE DIRECTIVES (SUCH AS A LIVING WILL OR A POWER OF ATTORNEY)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores.

You can sometimes get advance directive forms from organizations that give people information about Medicare. Section 1 of this booklet tells how to contact your SHIP, which stands for **S**tate **H**ealth **I**nsurance Assistance **P**rogram. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with:

Pennsylvania Department of Health
Bureau of Quality Assurance
Health & Welfare Building, Room 907
Harrisburg, PA 17120
Phone: 1-717-787-8015

YOUR RIGHT TO MAKE COMPLAINTS

You have the right to make a complaint if you have concerns or problems related to your coverage or care. A complaint can be called a grievance, an organization determination, or a coverage determination depending on the situation. See Section 8 for more information about complaints.

If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our plan in the past. To get this information, call Member Services.

YOUR RIGHT TO GET INFORMATION ABOUT OUR PLAN, PLAN PROVIDERS, HEALTH CARE COVERAGE, AND COSTS

This booklet tells you what medical services are covered for you as a plan member and what you have to pay.

If you need more information, please call Member Services at the number in Section 1 of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by our plan. We must tell you in writing why we will not pay for or approve a service, and how you can file an appeal to ask us to change this decision. See Section 8 for more information about filing an appeal.

You also have the right to get information from us about our plan. This includes information about our financial condition, about our plan health care providers and their qualifications, about information on our network pharmacies, and about how our plan compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Member Services at the phone number in Section 1 of this booklet. You have the right under law to have a written/binding advance coverage determination made for the service, even if you obtain this service from a provider not affiliated with our organization.

HOW TO GET MORE INFORMATION ABOUT YOUR RIGHTS

If you have questions or concerns about your rights and protections, please call Member Services at the number in Section 1 of this booklet. You can also get free help and information from your SHIP (contact information for your SHIP in Section 1 of this booklet). You can also visit **www.medicare.gov** on the Web to view or download the publication *Your Medicare Rights & Protections*. Under "Search Tools," select "Find a Medicare Publication." Or, call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

What to do if you think you have been treated unfairly or your rights are not being respected

If you think you have been treated unfairly or your rights have not been respected, you may call Member Services or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at **1-800-368-1019** or **TTY/TDD 1-800-537-7697**, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP (contact information for your SHIP is in Section 1 of this booklet).

YOUR RESPONSIBILITIES AS A MEMBER OF OUR PLAN

Your responsibilities include the following:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services if you have any questions.
- Letting us know if you have additional health insurance coverage.
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our plan. You must present your plan enrollment card to the provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions, and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- Paying your copayments/coinsurance for your covered services. You must pay for services that aren't covered.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the phone number in Section 1 of this booklet.

What can you do if you think you have been treated unfairly or your rights aren't being respected?

For concerns or problems related to your Medicare rights and protections described in this section, you may call our Member Services numbers listed in Section 1. You can also get help from your State Health Insurance Assistance Program, or SHIP (contact information for your SHIP is in Section 1 of this booklet).

Section 6 – General Exclusions

INTRODUCTION

The purpose of this section is to tell you about medical care, services, and items that aren't covered ("are excluded") or are limited by our plan. The list below tells about these exclusions and limitations. The list describes services and items that aren't covered under any conditions and some services that are covered only under specific conditions. (The Benefits Chart in Section 3 also explains about some restrictions or limitations that apply to certain services).

IF YOU GET SERVICES OR ITEMS THAT ARE NOT COVERED, YOU MUST PAY FOR THEM YOURSELF

We won't pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will the Original Medicare Plan, unless they are found upon appeal to be services and items that we should have paid or covered (appeals are discussed in Section 8).

What services are not covered or are limited by our plan?

In addition to any exclusions or limitations described in the Benefits Chart in Section 3, or anywhere else in this booklet, **the following items and services aren't covered except as indicated by our plan:**

1. Services that aren't covered under the Original Medicare Plan.
2. Services that aren't reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our plan as a covered service.
3. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. In 2008, CMS will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to Medicare Advantage plan members. Experimental procedures and items are those items and procedures determined by our plan and the Original Medicare Plan to not be generally accepted by the medical community.
4. Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare Plan.
5. Private room in a hospital, unless medically necessary.
6. Private duty nurses.
7. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
8. Nursing care on a full-time basis in your home.
9. Custodial care unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating, and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
10. Homemaker services.
11. Charges imposed by immediate relatives or members of your household.
12. Meals delivered to your home.

13. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
14. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as the unaffected breast, to produce a symmetrical appearance.
15. Chiropractic care is generally not covered under the plan (with the exception of manual manipulation of the spine, as outlined in Section 3) and is limited according to Medicare guidelines.
16. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
17. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic oot disease.
18. Supportive devices for the feet. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Hearing aid and eye wear repairs and/or replacements are not covered.
20. Eyeglasses (except after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
21. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
23. Acupuncture.
24. Naturopath services.
25. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan cost-sharing amount.
26. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.
27. Wigs and other items intended to replace hair loss due to male/female pattern baldness or due to illness or injury including, but not limited to, injury due to traumatic or surgical scalp abrasion, burns, or chemotherapy.

Section 7 – How to File a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an organization determination, a coverage determination, or an appeal, as described in Section 8 of this manual. Grievances do not involve problems related to approving or paying for care, problems about having to leave the hospital too soon, and problems about having **S**killed **N**ursing **F**acility (SNF), **H**ome **H**ealth **A**gency (HHA), or **C**omprehensive **O**utpatient **R**ehabilitation **F**acility (CORF) services ending too soon.

If we will not give you the services you want, you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined in Section 8.

What types of problems might lead to your filing a grievance?

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) the plan.
- Problems with the service you receive from Member Services.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when you need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in more detail in Section 8.
- You believe our notices and other written materials are hard to understand.
- We don't give you a decision within the required time frame (on time).
- We don't forward your case to the independent review entity if we do not give you a decision on time.
- We don't give you required notices.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss fast grievances in more detail in Section 8.

Filing a grievance with our plan

If you have a complaint, please call the phone number for **Part C Grievances** in Section 1 of this booklet. We will try to resolve your complaint over the phone. If you ask for a written response, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints.** We call this the Grievance Complaint process. To use the formal grievance procedure, submit your grievance in writing to: Keystone 65 Medicare Member Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652. We must address your grievance as quickly as your case requires based on your health status but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

EXPEDITED GRIEVANCE PROCESS

As a member, you can file an expedited grievance with Keystone 65 for the following reasons:

- Keystone 65's decision to invoke an extension to the organization determination or reconsideration time frames.
- Keystone 65's refusal to grant a member's request for an expedited organization determination or reconsideration.

Keystone 65 must respond within 24 hours of receiving your expedited grievance request. To file an expedited grievance, please call **1-800-645-3965 (TTY/TDD: 1-888-857-4816)** seven days a week, 8 a.m. to 8 p.m., or mail a written request to Medicare Member Appeals Unit, 1901 Market Street, P.O. Box 13652, Philadelphia, PA 19101-3652.

FOR QUALITY OF CARE PROBLEMS, YOU MAY ALSO COMPLAIN TO THE QIO

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to an independent review organization called the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 1 for more information about the QIO.

HOW TO FILE A QUALITY OF CARE COMPLAINT WITH THE QIO

You must write to the QIO to file a quality of care complaint. You may file your complaint with the QIO at any time. See Section 1 for more information about how to file a quality of care complaint with the QIO.

Section 8 – What To Do if You Have Complaints About Your Part C Medical Services and Benefits

INTRODUCTION

This section gives the rules for making complaints about Part C services and payments in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with your medical care as a plan member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled or penalized in any way if you make a complaint.

Please refer to original Medicare in your 2008 *Medicare & You* handbook for additional guidance on your appeal rights under original Medicare. If you do not have a *Medicare & You* handbook, please call **1-800-MEDICARE** to get a copy.

HOW TO MAKE COMPLAINTS IN DIFFERENT SITUATIONS

This section tells you how to make a complaint about services or payment disputes in each of the following situations:

Part 1. Complaints about what benefit or service we will approve or what we will pay for.

Part 2. Complaints if you think you are asked to leave the hospital too soon.

Part 3. Complaints if you think your skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

If you want to make a complaint about any situation not listed above, you may file a **grievance**. **For more information about grievances, see Section 7.**

PART 1. COMPLAINTS ABOUT WHAT BENEFIT OR SERVICE THE PLAN WILL APPROVE OR WHAT THE PLAN WILL PAY FOR

What are "complaints about your services or payment for your care"?

- If you are not getting the care you want, and you believe that this care is covered by the plan.
- If we will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the plan.
- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by the plan, but we have refused to pay for this care because we say it is not medically necessary or is not a plan benefit.

What is an organization determination?

An "organization determination" is our **initial decision** about whether we will provide the medical care or service you request, or pay for a service you have received.

If our initial decision is to deny your request, you may **appeal** the decision by going to Appeal Level 1 (see page 59). You may also appeal if we fail to make a timely initial decision on your request.

When we make an organization determination, we are giving our interpretation of how the benefits and services that are covered for members of the plan apply to your specific situation. This booklet, and any amendments you may receive, describe the benefits and services covered by the plan, including any limits on these services. This booklet also lists services that are not covered by the plan.

Who may ask for an organization determination about your medical care or payment?

Your doctor or other medical provider may ask us whether we will approve the treatment. You may also ask us for an initial decision, or you can name (appoint) someone to do it for you. This person you name would be your representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to be your representative. This statement must be sent to us at the address listed under **Part C Organization Determinations** in Section 1 of this booklet. Please call us at the phone number shown under **Part C Organization Determinations** for more information. You also have the right to have a lawyer act for you. You can get your own lawyer or find a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to call the Pennylvania Bar Association at **1-717-238-6715**.

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will pay for or approve medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days), or it can be a "fast decision" that is made more quickly (typically within 72 hours). A fast decision is also called an "expedited organization determination." You may ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

Asking for a standard decision

To ask for a standard decision about providing medical care or payment for care, you or your representative should mail or deliver a request **in writing** to the address listed under **Part C Organization Determinations** in Section 1 of this booklet.

Asking for a fast decision

You, any doctor, or your representative can ask us to give a fast decision (rather than a standard decision) about medical care by calling us. Or, you may send or fax us a written request to the fax number or address listed under **Part C Organization Determinations** in Section 1 of this booklet. Be sure to ask for a "fast" or "72-hour" review.

If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that you don't need a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast decision, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast grievance." If we deny your request for a fast decision, we will give you a standard decision. For more information about grievances, see Section 7.

What happens next when you request an initial decision?

1. **For a decision about payment for care you already received:**

   We have 30 days to make a decision after we receive your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the time frame for making a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 days of your request, you can appeal this decision. (An appeal is also called a "reconsideration.")

2. **For a standard decision about medical care:**

   We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a "fast grievance." If we do not approve your request, we must explain why in writing and tell you of your right to appeal our decision. If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

3. **For a fast decision about medical care:**

   If you request a "fast" decision, we will give you our decision about your requested medical care within 72 hours after you or your doctor ask for it — sooner if your health requires. However, we can take up to 14 more days if we find that some information is missing that may benefit you or if you need more time to prepare for this review. If you believe that we should not take any extra days, you can file a fast grievance.

We will call you as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within three calendar days of calling you. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request, and you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

APPEAL LEVEL 1: IF WE DENY ANY PART OF YOUR REQUEST FOR A SERVICE OR PAYMENT OF A SERVICE, YOU MAY ASK US TO RECONSIDER OUR DECISION. THIS IS CALLED AN "APPEAL" OR A "REQUEST FOR RECONSIDERATION."

Please call us if you need help in filing your appeal. We give the request to different people than those who made the organization determination. This helps ensure that we will give your request a fresh look.

If your appeal concerns a decision we made about a service you asked for, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" appeal are the same as those described for a "standard" or "fast" initial decision.

Getting information to support your appeal

If we need your help in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get your doctor's records or your doctor's opinion to support your request. You may need to give your doctor a written request to get information.

You can give us additional information to support your appeal by calling, faxing, or writing to the numbers or address listed under **Part C Appeals** in Section 1 of this booklet. You can also deliver additional information in person to the address listed under **Part C Appeals** in Section 1 of this booklet. You also have the right to ask us for a copy of the information we have regarding your appeal. You may call or write us at the numbers or address listed under **Part C Appeals** in Section 1 of this booklet.

How do you file your appeal of the organization determination?

The rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an 'organization determination' about medical care or payment?" However, providers who do not have a contract with the plan must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You must file your appeal within 60 days after we notify you of our decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal, you may call or write us at the phone number or address listed under **Part C Appeals** in Section 1 of this booklet.

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal are the same as the rules about asking for a "fast" decision. See page 58 for details.

How soon must we decide on your appeal?

1. **For a decision about payment for care you already received:**

   After we receive your appeal, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

2. **For a standard decision about medical care:**

   After we receive your appeal, we have 30 days to decide but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

3. **For a fast decision about medical care:**

   After we receive your appeal, we have 72 hours to decide but will decide sooner if your health requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens next if we rule completely in your favor?

1. **For a decision about payment for care you already received:**

   We must pay within 60 days of the day we received your appeal.

2. **For a standard decision about medical care:**

   We must authorize or provide your requested care within 30 days of receiving your appeal. If we extended the time needed to decide your appeal, we will authorize or provide your medical care immediately.

3. **For a fast decision about medical care:**

   We must authorize or provide your requested care within 72 hours of receiving your appeal — or sooner, if your health requires it. If we extended the time needed to decide your appeal, we will authorize or provide your medical care immediately.

APPEAL LEVEL 2: IF ON YOUR LEVEL 1 APPEAL, WE DO NOT RULE COMPLETELY IN YOUR FAVOR, YOUR APPEAL WILL AUTOMATICALLY BE REVIEWED BY AN INDEPENDENT REVIEW ENTITY

If we do not rule completely in your favor, your appeal is automatically sent to Appeal Level 2 where an independent review entity that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program and is not part of the plan, will review your appeal. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal depends on the type of appeal.

1. **For a decision about payment for care you already received:**

   We must forward your appeal to the independent review entity within 60 days of the date we received your Level 1 appeal.

2. **For a standard decision about medical care:**

   We must forward your appeal to the independent review entity as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

3. **For a fast decision about medical care:**

   We must forward your appeal to the independent review entity within 24 hours of our decision.

We will send the independent review entity a copy of your case file. You also have the right to get a copy of your case file from us by calling or writing us at the phone number or address listed under **Part C Appeals** in Section 1 of this booklet.

How soon must the independent review entity decide?

See chart on Page 64.

1. For an appeal about payment for care, the independent review entity has 60 days to make a decision.
2. For a standard appeal about medical care, the independent review entity has 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.
3. For a fast appeal about medical care, the independent review entity has 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

If the independent review entity decides completely in your favor:

The independent review entity will tell you in writing about its decision.

1. **For an appeal about payment for care:**

   We must pay within 30 days after receiving the decision.

2. **For a standard appeal about medical care:**

   We must authorize the care you requested within 72 hours after receiving the decision or provide the care no later than 14 days after receiving the decision.

   We must authorize or provide the care no later than 14 days after receiving the decision. If it is not appropriate to provide the service within 14 calendar days, e.g., because of your medical condition or you are outside of the service area, we must authorize the services within 72 hours from the date we receive notice that the independent review entity reversed the determination.

3. **For a fast appeal about medical care:**

   We must authorize or provide the care you requested within 72 hours after receiving the decision.

APPEAL LEVEL 3: IF THE ENTITY THAT REVIEWS YOUR CASE IN APPEAL LEVEL 2 DOES NOT RULE COMPLETELY IN YOUR FAVOR, YOU MAY ASK FOR A REVIEW BY AN ADMINISTRATIVE LAW JUDGE

You must ask for a review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. They may extend the deadline for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you received from the independent review organization. The Administrative Law Judge will not review the appeal if the dollar value of the medical care does not meet the minimum requirement included in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by a lawyer.

How soon will the judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and decide as soon as possible.

If the judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 days of the date we receive notice of the decision. However, we have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

APPEAL LEVEL 4: IF THE JUDGE DOES NOT RULE COMPLETELY IN YOUR FAVOR, YOU MAY ASK FOR A REVIEW BY THE MEDICARE APPEALS COUNCIL

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or we may ask for a review by a Federal Court Judge (Appeal Level 5). The Medicare Appeals Council will send a notice informing you of any action it has taken on your request. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the council make a decision?

If the Medicare Appeals Council reviews your case, they will decide as soon as possible.

If the council decides in your favor

We must pay for, authorize, or provide the medical care you requested within 60 days of the date we receive the decision. However, we have the right to ask a Federal Court Judge to review the case (Appeal Level 5), as long as the dollar value of the care you asked for meets the minimum requirement.

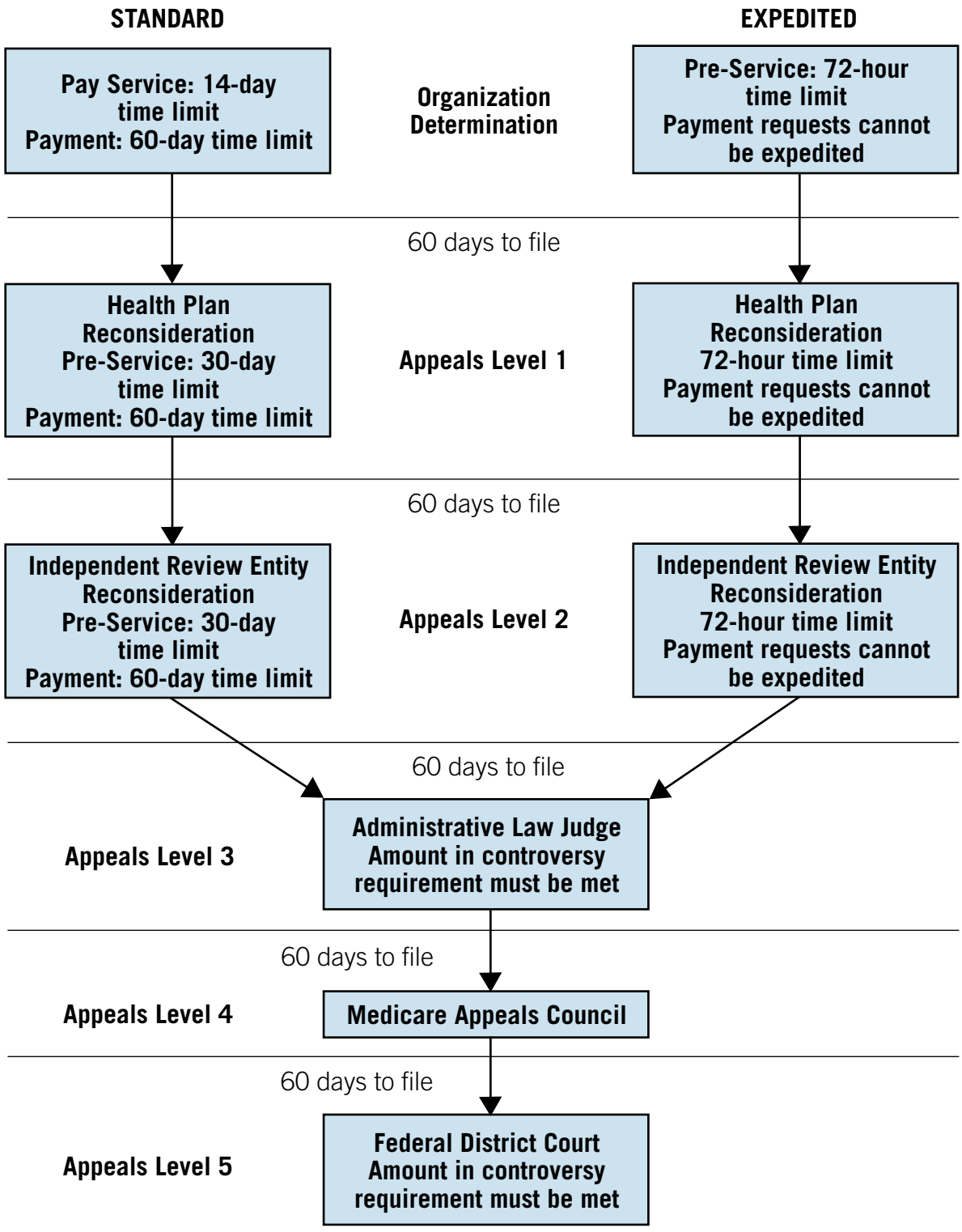
APPEAL LEVEL 5: IF THE MEDICARE APPEAL COUNCIL DOES NOT RULE COMPLETELY IN YOUR FAVOR, YOU MAY ASK FOR A REVIEW BY A FEDERAL COURT

You may file an appeal in federal court if you receive a decision from the Medicare Appeals Council (MAC) that is not completely favorable to you or the MAC decided not to review your case. The letter you get from the MAC will tell you how to ask for this review. The Federal Court Judge will first decide whether to review your case. Your appeal will not be reviewed by a federal court if the dollar value of the care you asked for does not meet the minimum requirement included in the MAC's decision.

How soon will the judge make a decision?

The federal judiciary controls the timing of any decision. The judge's decision is final.

COMPLAINT PROCESS FOR WHAT BENEFIT OR SERVICE THE PLAN WILL APPROVE OR WHAT THE PLAN WILL PAY FOR



PART 2. COMPLAINTS (APPEALS) IF YOU THINK YOU ARE BEING DISCHARGED FROM THE HOSPITAL TOO SOON

When you are admitted to the hospital, you have the right to get all the hospital care covered by the plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer medically necessary. This part explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

Within two days of admission as an inpatient, someone at the hospital must give you a notice called the Important Message from Medicare (call our Plan Member Services at the phone number listed in Section 1 or **1-800 MEDICARE (1-800-633-4227)** to get a sample notice or see it online at **www.cms.hhs.gov/BNI**. This notice explains:

- Your right to get all medically necessary hospital services paid for by the plan (except for any applicable copayments or deductibles).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable copayments or deductibles).

You (or your representative) will be asked to sign the Important Message from Medicare to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your services should end — only that you received and understand the notice.** If the hospital gives you the Important Message from Medicare more than two days before your discharge day, it must give you a copy of your signed Important Message from Medicare before you are scheduled to be discharged

REVIEW OF YOUR HOSPITAL DISCHARGE BY THE QUALITY IMPROVEMENT ORGANIZATION

You have the right to request a review of your discharge. You may ask a Quality Improvement Organization to review whether you are being discharged too soon.

What is the "Quality Improvement Organization"?

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting QIO review of your hospital discharge

You must quickly contact the QIO. The Important Message from Medicare gives the name and telephone number of the QIO and tells you what you must do.

- You must ask the QIO for a **"fast review"** of your discharge. This fast review is also called an "immediate review."
- You must request a review from the QIO no later than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from the QIO.**
- The QIO will look at your medical information provided to the QIO by us and the hospital.
- During this process, you will get a notice giving our reasons why we believe that your discharge date is medically appropriate.
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if the QIO decides in your favor?

We will continue to cover your hospital stay for as long as it is medically necessary (except for any applicable copayments or deductibles).

What happens if the QIO agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gave you its first decision.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care as long as it is medically necessary (except for any applicable copayments or deductibles).

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge. Please see Appeal Level 3 in Part 1 of this section for guidance on the **A**dministrative **L**aw **J**udge (ALJ) appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the **M**edicare **A**ppeals **C**ouncil (MAC) or a federal court. If any of these decision makers (Administrative Law Judge, Medicare Appeal Council, federal court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date and provide you with inpatient care as long as it is medically necessary (except for any applicable copayments or deductibles).

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as it is medically necessary (except for any applicable copayments r deductibles).
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the independent review entity within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Entity (IRE) appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a federal court. If any of these decision makers (Independent Review Entity, Administrative Law Judge, Medicare Appeal Council, federal court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable copayments or deductibles).

PART 3. COMPLAINTS (APPEALS) IF YOU THINK COVERAGE FOR YOUR SKILLED NURSING FACILITY, HOME HEALTH AGENCY, OR COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES IS ENDING TOO SOON

When you are a patient in a **S**killed **N**ursing **F**acility (SNF), **H**ome **H**ealth **A**gency (HHA), or **C**omprehensive **O**utpatient **R**ehabilitation **F**acility (CORF), you have the right to get all the SNF, HHA, or CORF care covered by the plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA, or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

INFORMATION YOU WILL RECEIVE DURING YOUR SNF, HHA, OR CORF STAY

Your provider will give you written notice called the Notice of Medicare Non-Coverage at least two days before coverage for your services ends (call the plan Member Services phone number in Section 1 or **1-800-Medicare (1-800-633-4227)** to get a sample notice, or see it online at **www.cms.hhs.gov/BNI**. You (or your representative) will be asked to sign and date this notice to show that you received it. **Signing the notice does not mean that you agree that coverage for your services should end — only that you received and understood the notice.**

GETTING QIO REVIEW OF OUR DECISION TO END COVERAGE

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask the **Q**uality **I**mprovement **O**rganization (the QIO) to do an independent review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask for QIO review?

You must quickly contact the QIO. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice two days before your coverage ends, you must contact the QIO no later than noon of the day after you get the notice.
- If you get the notice more than two days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends.

What will happen during the QIO's review?

The QIO will ask why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review information that we have given to the QIO. During this process, you will get a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for your services should end (call the plan Member Services phone number in Section 1 or **1-800-MEDICARE** to get a sample notice or see it online at **www.cms.hhs.gov/BNI**).

The QIO will make a decision within one full day after it receives all the information it needs.

What happens if the QIO decides in your favor?

We will continue to cover your SNF, HHA, or CORF services for as long as they are medically necessary (except for any applicable copayments or deductibles).

What happens if the QIO agrees that your coverage should end?

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIOs first denial of your request.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider and provide you with any services you asked for as long as they are medically necessary (except for any applicable copayments or deductibles).

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council or a federal court. If either the Medicare Appeal Council or federal court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider and provide you with any services you asked for as long as they are medically necessary (except for any applicable copayments or deductibles).

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a review by the deadline, you may ask us for a fast appeal, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your coverage ending and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you get after your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services for as long as they are medically necessary.
- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the independent review entity within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the **I**ndependent **R**eview **E**ntity (IRE) appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a federal court. If any of these decision makers (Independent Review Entity, Administrative Law Judge, Medicare Appeal Council, federal court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider and provide you with any services you asked for, as long as they are medically necessary (except for any applicable copayments or deductibles).

Section 9 — Ending Your Membership

Ending your membership in our plan may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our plan because you have decided that you want to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

VOLUNTARILY ENDING YOUR MEMBERSHIP

In general, there are only certain times during the year when you may voluntarily end your membership in our plan.

Every year, from November 15 through December 31, during the Annual Coordinated Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1.

There may be other limited times during which you may make changes. For more information about these times and the options available to you, please refer to the *Medicare & You* handbook you receive each fall. You may also call **1-800-MEDICARE** (**1-800-633-4227**), or visit **www.medicare.gov** to learn more about your options.

UNTIL YOUR MEMBERSHIP ENDS, YOU MUST KEEP GETTING YOUR MEDICARE SERVICES THROUGH OUR PLAN OR YOU WILL HAVE TO PAY FOR THEM YOURSELF

If you leave our plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through our plan.

If you must get services from plan providers and doctors or other medical providers who are not plan providers before your membership in our plan ends, neither we nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by us. There is another possible exception: if you happen to be hospitalized on the day your membership ends. If this happens to you, call Member Services to find out if your hospital care will be covered by our plan. If you have any questions about leaving our plan, please call us at Member Services.

WE CANNOT ASK YOU TO LEAVE THE PLAN BECAUSE OF YOUR HEALTH

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave Keystone 65 because of your health, you should call **1-800-MEDICARE** (**1-800-633-4227**), which is the national Medicare help line. TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

INVOLUNTARILY ENDING YOUR MEMBERSHIP

If any of the following situations occur, we will end your membership in our plan.

- If you move out of the service area or are away from the service area for more than 6 months in a row. If you plan to move or take a long trip, please call Member Services to find out if the place you are moving to or traveling to is in our plan's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row, you cannot remain a member of Keystone 65. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you). Section 2 gives more information about getting care when you are away from the service area.
- If you do not stay continuously enrolled in both Medicare A and B.
- If you give us information on your enrollment request that you know is false or deliberately misleading, and it affects whether or not you can enroll in our plan.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our plan. We cannot make you leave our plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.

YOU HAVE THE RIGHT TO MAKE A COMPLAINT IF WE END YOUR MEMBERSHIP IN OUR PLAN

If we end your membership in our plan, we will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

Section 10 – Legal Notices

NOTICE ABOUT GOVERNING LAW

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state of Pennsylvania may apply.

NOTICE ABOUT NONDISCRIMINATION

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans or Medicare Prescription Drug Plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

LIABILITY FOR CHARGES

In the event Keystone 65 fails to reimburse a plan medical provider's charges for covered services, or in the event we fail to pay a non-plan medical provider for prior authorized services, you shall not be liable for any sums owed by Keystone 65.

However, you will be liable if you receive services from non-plan (out-of-network) providers without prior authorization (approval in advance), except for emergency services, urgently needed services, or out-of-area dialysis services, which are provided within the United States. Neither Keystone 65 nor Medicare will pay for those services. In addition, if you enter into a private contract with a non-plan (out-of-network) provider, neither Keystone 65 nor Medicare will pay for those services.

Section 11 — Provider Reimbursement Information

HOW WE PAY PROVIDERS

Our 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 plan (in-network) provider. These programs vary by state. Please note that these programs may change from time to time, and the arrangements with particular plan (in-network) 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 Member Services.

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 **Q**uality **I**ncentive **P**ayment **S**ystem (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 delivery.

Designated Specialty Sites: For a few specialty services, PCPs are required to select a designated site to which they refer all of our HMO patients for those services. The specialist services for which PCPs must select a designated site vary by state and could include, but are not limited to, radiology, physical therapy, and podiatry. Specialists in designated sites 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, members may want to speak to the PCP regarding the designated specialty sites that the 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 these 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 area 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.

PHYSICIAN GROUP PRACTICES AND PHYSICIAN ASSOCIATIONS

Certain physician group practices and Independent Practice Associations (IPAs) employ or contract with individual physicians to provide medical covered services. These groups are paid as outlined under "Professional Providers" above. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or 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 contracted 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 less than a one-percent ownership interest in this behavioral health management company.

PHARMACY

A pharmacy benefits management company (PBM) which is an affiliate of the plan administers our HMO pharmacy benefits, provides a network of plan pharmacies and processes pharmacy claims. The PBM is paid an administrative fee for processing each pharmacy claim and providing other pharmacy related services. 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. These rebates and discounts reduce the overall cost of pharmacy benefits.

Section 12 — Definition of Some Words Used in This Book

Allowed Amount — is the eligible dollar amount of covered services. The allowed amount will be determined based on:

A. When care is provided, not when payment is made; and

B. Whether the provider is a plan (in-network) provider or a plan (in-network) facility provider.

(i) The allowed amount for covered services provided by a plan facility provider is the billed charge for that covered service reduced by the plan-wide discount in effect for the time period in which the covered services are provided.

(ii) The allowed amount for covered services provided by a plan professional provider is the amount determined by the Keystone 65 Fee Schedule.

Appeal — An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for a Part D drug benefit or payment for a Part D drug benefit you already received. There is a specific process that your Part D plan sponsor must use when you ask for an appeal. Section 8 explains what appeals are, including the process involved in making an appeal.

Balance Billing — Means charging or collecting from a Medicare beneficiary an amount in excess of the reimbursement rate for Medicare-covered services or supplies provided to a Medicare beneficiary except when Medicare is the secondary insurer. "Balance billing" does not include charging or collecting deductibles, cost-shares, or coinsurance required by the plan.

Benefit period — For both our plan and the Original Medicare Plan, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually get during the stay determines whether you are considered an inpatient for SNF stays but not for hospital stays.

You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both. (Section 2 tells what is meant by skilled care.)

Generally, you are an inpatient of a hospital if you are getting inpatient services in the hospital (the type of care you actually receive in the hospital doesn't determine whether you are considered an inpatient in the hospital).

Centers for Medicare & Medicaid Services (CMS) — The federal agency that runs the Medicare program. Section 1 explains how to contact CMS.

Cost-sharing — Cost-sharing refers to amounts that a member has to pay when services are received. It includes any combination of the following three types of payments: (1) any deductible amount the plan may impose before services are covered; (2) any fixed "copayment" amounts that a plan may require be paid when specific services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a service.

Coverage Determination —

1) The plan has made a coverage determination when it makes a decision about the benefits you can receive under the plan, and the amount that you must pay for those benefits.
2) A decision from your Medicare drug plan about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

Covered Services — The general term we use in this booklet to mean all of the health care services and supplies that are covered by our plan. Covered services are listed in the Benefits Chart in Section 3.

Creditable Coverage — Coverage that is at least as good as the standard Medicare prescription drug coverage.

Disenroll or Disenrollment — The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 9 discusses disenrollment.

Durable Medical Equipment — Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment are wheelchairs, hospital beds, and equipment that supplies a person with oxygen.

Emergency Care — Covered services that are:

1) Rendered by a provider qualified to furnish emergency services; and
2) Needed to evaluate or stabilize an emergency medical condition. Section 2 tells about emergency services.

Evidence of Coverage and Disclosure Information — This document, along with your enrollment form and any other attachments, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Facility Provider — An institution or entity licensed, where required, to provide care. Such facilities include:

- Ambulatory surgical facility
- Birthing center
- Free-standing dialysis facility
- Free-standing ambulatory care facility
- Home health care agency
- Hospice
- Hospital
- Non-hospital facility
- Psychiatric hospital
- Rehabilitation hospital
- Residential treatment facility
- Short procedure unit

Grievance — A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint doesn't involve payment or coverage disputes. See Section 7 for more information about grievances.

Inpatient Care — Health care that you get when you are admitted to a hospital.

Letter of Coverage — The document that indicates the benefit plan you have selected.

Limited Circumstances — If you are traveling between Alaska and another state, services provided in Canada are covered. Medicare also covers hospital, ambulance, and doctors' services if you are in the United States but the nearest hospital that can treat you is not in the United States. (Please note: The United States includes all 50 states, as well as the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.) This coverage includes services that you receive on board a ship, as long as you are in the territorial waters adjoining the land areas of the United States.

Medically necessary — "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purposes of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards or medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Medicare — The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization — Medicare Advantage plans are run by private companies. They give you more options and sometimes extra benefits. These plans are still part of the Medicare Program and are also called "Part C." They provide all your Part A (Hospital) and Part B (Medical) coverage.

Medicare Advantage Plan — A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plans in the same service area. We are a Medicare Advantage Organization.

Medicare Cost Plan — Cost plan means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Managed Care Plan — Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

Medicare Prescription Drug Coverage — Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B.

"Medigap" (Medicare supplement insurance) Policy — Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan.

Member (member of our plan) — A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services — A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Member Services.

Non-plan Provider or Non-plan Facility — A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Non-plan providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers are not covered by our plan or Original Medicare.

Organization Determination — The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about Medicare Advantage services or payment that you believe you should receive.

Original Medicare — Some people call it "traditional Medicare" or "fee-for-service" Medicare. The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Plan Provider — "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "plan providers" when they have an agreement with our plan to accept our payment as payment in full and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays plan providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services.

Primary Care Physician (PCP) — A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 2 tells more about PCPs.

Prior authorization — Approval in advance to get services. In an HMO with a referral model and in the network portion of a PPO, some in-network services are covered only if your doctor or other plan provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Section 3. In a PPO and PFFS plan, you do not need prior authorization to obtain out-of-network services. However, you may want to check with your plan before obtaining services out-of-network to confirm that the service is covered by your plan and what your cost share responsibility is. If your plan offers Part D drugs, certain drugs may require prior authorization. Check with your plan.

Professional Provider — A person or practitioner who is licensed where required and performs services within the scope of such licensure. The professional providers are:

- audiologist
- certified registered nurse
- chiropractor
- clinical laboratory
- dentist
- nurse midwife
- optometrist
- osteopath
- physical therapist
- physician
- podiatrist
- speech-language pathologist
- teacher of the hearing impaired

Quality Improvement Organization (QIO) — Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 1 for information about how to contact the QIO in your state and Section 8 for information about making complaints to the QIO.

Rehabilitation services — These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider.

Referral — A written or electronic order from your Primary Care Provider approving you in advance to see a specialist or get certain services.

Service Area — A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a prescription drug sponsor.

Urgently needed care — Section 2 explains about "urgently needed" services. These are different from emergency services.

NOTES

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Independence
Blue Cross

1901 Market Street
Philadelphia, PA 19103

www.site65.com

If you are a **member** and have questions,
please call **toll free, 1-800-645-3965**
(TTY/TDD: 1-888-857-4816)
Seven days a week 8 a.m. to 8 p.m.

If you are **not yet a member** and have questions,
please call **toll free, 1-877-393-6733**
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