Trigon HealthKeepers
Offered by HealthKeepers, Inc.

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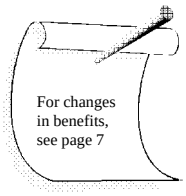
http://www.trigon.com/federal

# 2001

## A Health Maintenance Organization




**Serving:**
**Eastern Virginia,** including the Peninsula, Hampton Roads and Tidewater areas;
**Central Virginia,** including Fredericksburg, Richmond, Charlottesville and Southside areas;
**Western Virginia,** including Roanoke, Lexington, and Bedford areas; and
**Southwestern Virginia,** including the Wytheville and New River Valley areas.

**Enrollment in this Plan is limited; see page 6 for requirements.**

*This Plan has excellent accreditation from the NCQA. See the 2001 Guide for more information on NCQA.*

**Enrollment codes for this Plan:**

**X81 Self Only**
**X82 Self and Family**

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service

Federal Employees
Health Benefits Program

RI 73-235

## Table of Contents

## Introduction

HealthKeepers, Inc.
P.O. Box 26623
Richmond, VA 23285-0031
800/421-1880

This brochure describes the benefits of Trigon HealthKeepers, offered by HealthKeepers, Inc., under our contract (CS 2091) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 51. Rates are shown at the end of this brochure.

## Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means HealthKeepers, Inc.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

## Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

**You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.**

**How we pay providers**

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

**Who provides my health care?**

HealthKeepers, Inc. is a mixed model HMO offering both the individual practice and group practice modes of delivery. Members have access to all Plan specialists when authorized by their primary care doctor.

**Patients' Bill of Rights**

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below:

· We receive financial credits from drug manufacturers based on the total volume of claims processed for their products used by members. These credits are used to help stabilize premiums. Reimbursements to pharmacies are not affected by these credits.

If you want more information about us, call 800/421-1880, or write to HealthKeepers at P.O. Box 26623, Richmond, VA 23285-0031. You may also visit our website at www.trigon.com/federal.

**Service Area**

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is comprised of the following Virginia cities and counties:

**Central Virginia:** Albemarle, Amelia, Brunswick, Buckingham, Caroline, Charles City, Charlotte, Charlottesville, Chesterfield, Colonial Heights, Cumberland, Dinwiddie, Emporia, Fluvanna, Fredericksburg, Goochland, Greene, Greensville, Hanover, Henrico, Hopewell, King George, Louisa, Lunenburg, Madison, Mecklenburg, Nelson, New Kent, Nottoway, Orange, Petersburg, Powhatan, Prince Edward, Prince George, Richmond, Spotsylvania, Stafford, Sussex.

**Eastern Virginia:** Chesapeake, Essex, Gloucester, Hampton, Isle of Wight, James City, King and Queen, King William, Mathews, Middlesex, Newport News, Norfolk, Poquoson, Portsmouth, Richmond County, Suffolk, Surry, Virginia Beach, Westmoreland, Williamsburg, York.

**Western Virginia:** Bedford, Bedford City, Botetourt, Buena Vista, Craig, Franklin County, Floyd, Giles, Lexington, Montgomery, Pulaski, Radford, Roanoke, Roanoke City, Rockbridge, Salem, Tazewell, Wythe.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care, except as described below. We will not pay for any other health care services, except as described below.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependent lives out of the area (for example, your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas, such as HealthKeepers, Inc.

The Trigon HealthKeepers service area is the area in which HealthKeepers, Inc. is licensed to sell Trigon HealthKeepers coverage. However, we participate in *Blues***CONNECT,** the Blue Cross and Blue Shield Association's HMO national network, expanding your coverage to 43 states and the District of Columbia.

If you are traveling outside of the service area and have an unexpected illness or injury requiring urgent care, you can access your benefits by calling *Blues***CONNECT** at the number on your ID card. The coordinator will put you in touch with an affiliated Blue Cross and Blue Shield HMO near your location, and they will help you find a participating physician. You are not required to pay the provider when he or she renders the service; however, you will be responsible for your urgent care copayment when you return home. In the case of emergency, go to the nearest emergency facility.

If you are undergoing treatment for a medical condition and travel out of town, *Blues***CONNECT** allows you to schedule follow-up care with an affiliated Blue Cross and Blue Shield HMO.

Trigon HealthKeepers gives you and your covered dependents the flexibility to become **Guest Members** of an affiliated Blue Cross and Blue Shield HMO when staying outside the Trigon HealthKeepers service area for at least 90 days. *Blues***CONNECT** provides care for members on extended out of town trips, away at school, or when families live apart. To join, contact our Member Services Department for a Guest Membership application. An Away From Home coordinator will make all the necessary arrangements for you or your dependent to access your Trigon HealthKeepers benefits while away from home. A special Guest Membership ID card will be sent to you for your dependent to use when medical care is needed.

If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

## Section 2. How we change for 2001

**Program-wide changes**

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed day and visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling Member Services at 800/421-1880, **or** checking our website www.trigon.com/federal. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

**Changes to this Plan**

- Your share of the non-Postal premium will increase by 18.4% for Self Only or 23.9% for Self and Family.
- Hospital admissions and anesthesia for inpatient dental procedures are now a covered benefit. The member pays the regular $100 hospital admission copay.
- Insulin pumps no longer count toward the Durable Medical Equipment annual maximum of $1,000. Previously, insulin pumps were included.
- Coverage for glucometers is no longer limited. Previously, glucometers were limited to one per member every 12 months.
- We have added the following cities and counties in central and western Virginia: Brunswick, Buckingham, Charlotte, Emporia City, Greensville, Mecklenburg, Bedford City, Bedford County, Buena Vista City, Floyd, Lexington City, Rockbridge, Tazewell and Wythe.

## Section 3. How you get care

### Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800/421-1880.

### Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments; there are no deductibles or coinsurance, and you will not have to file claims in most circumstances.

Plan providers maintain the physician-patient relationship with you and are solely responsible for all medical services. The relationship between us and Plan providers is an independent contractor relationship. Plan providers are not our employees or agents and our employees are not employees or agents of any Plan provider.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

### What you must do

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Send us your completed Primary Care Physician Selection Form, found in your Trigon HealthKeepers Provider Directory for Federal Employees, immediately upon enrollment. If you do not select a primary care physician upon enrollment, we will select one for you.

- **Primary care**

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

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, without a referral you may see a Plan participating obstetrician-gynecologist for all services (except inpatient hospital services and outpatient surgery) in the care of or related to the female reproductive system and breasts.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a life-threatening, degenerative or disabling condition that requires specialized medical care over a prolonged period of time, your primary care physician will work with us to develop a treatment plan to see your specialist for a standing treatment period without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you have been diagnosed with cancer, you may get a standing referral from your primary care physician to another plan provider who is a board-certified physician in pain management or an oncologist. These providers shall consult with the primary care physician concerning the pain management plan, but not direct you to other health care services.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause; or

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  - reduce our service area and you enroll in another FEHB Plan,

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

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

**• Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800/421-1880. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or

- The day your benefits from your former plan run out; or

- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the hospital benefit of the hospitalized person.

## Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within our control resulting in our facilities, personnel or financial resources being unavailable to provide or arrange for the provision of covered services, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

## Services requiring our prior approval

We and your primary care physician will formally arrange for all necessary consultations and referrals to other plan providers or, if no plan provider is available, non-plan providers. Unauthorized visits to any provider other than your primary care physician are not covered services, unless otherwise specified herein. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process Referral Authorization. Your physician must obtain referrals for services such as: inpatient hospital, medical services provided by specialists, x-ray and laboratory, services in skilled nursing facilities, rehabilitation, home health care, durable medical equipment health education, and ambulance services.

## Section 4. Your costs for covered services

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

**• Copayments**

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

Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay $100 per admission.

**•Deductible**

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

**•Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care. We do not have coinsurance.

### Your out-of-pocket maximum for copayments

After your copayments total $1,500 per person or $3,000 per familyenrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs
- Dental services
- Vision care
- Chiropractic services

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

# Section 5. Benefits – OVERVIEW

***(See page 7 for how our benefits changed this year and page 51 for a benefits summary.)***

**NOTE**: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800/421-1880 or at our website at www.trigon.com/federal.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

| Benefit Description | You pay |
|---|---|
| **Diagnostic and treatment services** | |
| Professional services of physicians<br>· In physician's office | $10 per office visit to your primary care physician<br>$20 per office visit to a specialist when authorized by your primary care physician |
| Professional services of physicians<br>· In an urgent care center | $20 per visit to an urgent care center |
| · During a hospital stay | No copayment for physician services during a hospital stay |
| · In a skilled nursing facility | No copayment for physician services in a skilled nursing facility |
| · Initial examination of a newborn child covered under a family enrollment | No copayment for initial newborn examination at the hospital |
| · Office medical consultations<br>· Second surgical opinion | $10 per office visit to your primary care physician<br>$20 per office visit to a specialist when authorized by your primary care physician |
| At home | $20 per doctor's house call |

| Lab, X-ray and other diagnostic tests | You pay |
|---|---|
| Tests, such as:<br>· Blood tests<br>· Urinalysis<br>· Non-routine pap tests<br>· Pathology<br>· X-rays<br>· Non-routine Mammograms<br>· Cat Scans/MRI<br>· Ultrasound<br>· Electrocardiogram and EEG | Nothing if you receive these services during your office visit; otherwise,<br><br>$10 per office visit to your primary care physician,<br><br>$20 per office visit to a specialist when authorized by your primary care physician |
| **Preventive care, adult** | |
| Periodic health assessments (in accordance with recommendations of the American College of Physicians so long as they are consistent with accepted medical practices as we determine), such as:<br>· Screening x-rays<br>· Laboratory test services<br>· Prostate Specific Antigen (PSA test)<br>· Digital rectal examination<br>· Colorectal Cancer Screening (in accordance with recommendations of the American College of Gastroenterology, in consultation with the American Cancer Society), including<br>·· Fecal occult blood test<br>·· Flexible sigmoidoscopy<br>·· Colonoscopy<br>·· Barium enema | $10 per office visit to your primary care physician |
| Annual gynecological examination (which consists of a breast exam, pelvic exam and annual testing performed by any FDA-approved gynecologic cytology screening technologies, including Pap smears), when performed by your primary care physician or a Plan obstetrician-gynecologist. No primary care physician referral is necessary. | $10 per office visit |
| Routine mammogram–covered for women age 35 and older, as follows:<br>· From age 35 through 39, one during this five year period<br>· From age 40 through 64, one every calendar year<br>· At age 65 and older, one every two consecutive calendar years | $20 per office visit |
| Routine immunizations, in accordance with recommendations of the American College of Physicians and consistent with accepted medical practices. | $10 per office visit to your primary care physician |
| *Not covered: Physical exams required by court order, for obtaining or continuing employment or insurance, attending schools or camp, participating in sports, or travel.* | *All charges* |

| Preventive care, children | You pay |
|---|---|
| · Childhood immunizations recommended by the American Academy of Pediatrics | $10 per office visit to your primary care physician |
| · Periodic health assessments, such as:<br>·· Eye exams through age 18 to determine the need for vision correction.<br>·· Ear exams through age 18 to determine the need for hearing correction<br>· Well-child care including routine examinations, screening x-rays, and laboratory services (from birth through age 22) | $10 per office visit to your primary care physician |
| **Maternity care** | |
| Complete maternity (obstetrical) care, such as:<br>· Prenatal care<br>· Delivery<br>· Postnatal care<br>Here are some things to keep in mind:<br>· You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.<br>· We cover routine nursery care of the newborn child during the mother's covered maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.<br>· We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). | Nothing, no copayment for routine outpatient care<br>$20 per office visit for non-routine diagnostic testing<br>$100 per inpatient hospital admission |
| **Family planning** | |
| · Voluntary sterilization, including tubal ligations and vasectomies<br>· Prescription contraceptive devices | $10 per office visit to your primary care physician<br>$20 per office visit to a specialist when authorized by your primary care physician<br>$50 per visit for outpatient surgery received in a freestanding or hospital based center |
| *Not covered:*<br>· *reversal of voluntary surgical sterilization,*<br>· *Genetic counseling, genetic testing other than fetal screenings. Services for potential illnesses that may result from genetic pre-disposition are not covered in the absence of signs or symptoms.* | *All charges.* |
| **Infertility services** | **You pay** |
| Diagnosis and treatment of infertility, in accordance with standards of accepted medical practice as we determine and when authorized in advance, such as:<br>· Artificial insemination:<br>·· intravaginal insemination (IVI)<br>·· intracervical insemination (ICI)<br>·· intrauterine insemination (IUI) | $20 per office visit |

| | |
|---|---|
| *Not covered:*<br>· *Assisted reproductive technology (ART) procedures, such as:*<br>·· *in vitro fertilization*<br>·· *embryo transfer and GIFT*<br>· *Services and supplies related to excluded ART procedures*<br>· *Cost of donor sperm*<br>· *Fertility drugs* | *All charges.* |
| **Allergy care** | |
| Testing and treatment<br>Allergy injection | $10 per office visit to your primary care physician<br>$20 per office visit to a specialist when authorized by your primary care physician |
| Allergy serum | Nothing |
| *Not covered: provocative food testing and sublingual allergy desensitization* | *All charges.* |
| **Treatment therapies** | |
| · Chemotherapy and radiation therapy<br>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 23.<br>· Respiratory and inhalation therapy<br>· Dialysis – Hemodialysis and peritoneal dialysis<br>· Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy<br>· Growth hormone therapy (GHT) (Covered under prescription drug benefit)<br>Note: – We will only cover GHT when we preauthorize the treatment. Your physician handles the prior authorization process by sending a written request and applicable medical records to our Drug Prior Authorization Unit. | $10 per office visit to your primary care physician<br>$20 per office visit to a specialist when authorized by your primary care physician |
| **Rehabilitative therapies** | **You pay** |
| Physical therapy, occupational therapy and speech therapy --<br>· Up to 90 days per condition for the services of each of the following:<br>·· qualified physical therapists;<br>·· speech therapists; and<br>·· occupational therapists.<br>Note: We cover therapy only if we judge that significant improvement can be expected within 90 days.<br>· Cardiac rehabilitation, as we authorize as medically necessary and when performed by an HMO provider | $20 per office visit |
| *Not covered:*<br>· *long-term rehabilitative therapy*<br>· *exercise programs* | *All charges.* |
| **Hearing services (testing, treatment, and supplies)** | |
| · Hearing testing for children through age 18 (see *Preventive care, children*) | $10 per office visit |

| | |
|---|---|
| *Not covered:*<br>· *all other hearing testing*<br>· *hearing aids, testing and examinations for them* | *All charges.* |
| **Vision services (testing, treatment, and supplies)** | |
| · Vision screening to determine the need for vision correction for children through age 18 (see preventive care) | $10 per office visit |
| · Annual eye examination from the providers we designate to provide this service.<br>· Annual contact lens examination from the providers we designate to provide this service. | $10 per office visit<br>$25 per office visit, in addition to the $10 copayment for eye exam |
| *Not covered:*<br>· *Eyeglasses or contact lenses*<br>· *Radial keratotomy and other refractive surgery* | *All charges.* |
| **Foot care** | |
| · Podiatric services, limited to services for diabetic foot debridement | $10 per office visit to your primary care physician<br>$20 per office visit to a specialist when authorized by your primary care physician |
| *Not covered:*<br>· *Routine foot care, such as the removal of corns or calluses and the trimming of toenails* | *All charges.* |

| Orthopedic and prosthetic devices | You pay |
|---|---|
| · Rental or purchase, at our option, including repair and adjustment, of orthopedic and prosthetic devices prescribed by your Plan physician and authorized by us.<br>· Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy<br>Note: You must obtain orthopedic and prosthetic devices from the provider we designate. Limited to $1,000 per member per calendar year for any combination of orthopedic items, prosthetic devices, or Durable Medical Equipment. We calculate the $1,000 limit by accumulating the Allowable Charge for each item until you reach a total of $1,000 for any combination of items. | Nothing,<br>until you reach the maximum benefit of $1,000 per member per calendar year, then all charges. |
| *Not covered:*<br>· *Items for your convenience*<br>· *dental appliances*<br>· *hearing aids*<br>· *penile implants*<br>· *corrective appliances, artificial aids, devices, or equipment not specified as covered herein* | *All charges.* |
| **Durable medical equipment (DME)** | |
| · Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician and authorized by us, such as oxygen and dialysis equipment.<br>Note: You must obtain Durable Medical Equipment from the provider we designate. Limited to $1,000 per member per calendar year for any combination of orthopedic items, prosthetic devices, or Durable Medical Equipment. We calculate the $1,000 limit by accumulating the Allowable Charge for each item until you reach a total of $1,000 for any combination of items. Oxygen and related supplies are not subject to or counted toward this calendar year maximum. We do not consider any equipment or supplies used for the treatment of diabetes to be durable medical equipment and they are not be subject to or counted toward this calendar year maximum. | Nothing,<br>until you reach the maximum benefit of $1,000 per member per calendar year, then all charges. |
| *Not covered:*<br>· *Items for your convenience* | *All charges.* |

| Home health services | You pay |
|---|---|
| · Home health care ordered by a Plan physician and authorized by us and provided by a registered nurse (R.N.), licensed practical nurse (L..P.N), licensed vocational nurse (L.V.N.), or home health aide.<br>· Services include nursing care, short-term rehabilitative services, home infusion therapy, medical supplies and other medically necessary services, oxygen therapy, intravenous therapy and medications. | Nothing, |
| *Not covered:*<br>· *nursing care requested by, or for the convenience of, the patient or the patient's family;*<br>· *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*<br>· *Non-medical services* | *All charges.* |
| **Alternative treatments** | |
| Chiropractic services, from the providers we designate and when authorized by our contractor. | $10 per office visit,<br>limited to 20 visits per member per calendar year |
| *Not covered:*<br>· *Acupuncture*<br>· *Naturopathic services*<br>· *Hypnotherapy*<br>· *Biofeedback* | *All charges.* |
| **Educational classes and programs** | |
| We cover health education services when authorized or furnished by us. This includes outpatient self-management training and education therapy, including medical nutrition therapy, furnished in person to members with diabetes by a certified, registered or licensed health care professional. | $10 per office visit to your primary care physician<br>$20 per office visit to a specialist when authorized by your primary care physician |

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

IMPORTANT

| Benefit Description | You pay |
|---|---|
| **Surgical procedures** | |
| · Treatment of fractures, including casting<br>· Normal pre- and post-operative care by the surgeon<br>· Correction of amblyopia and strabismus<br>· Endoscopy procedure<br>· Biopsy procedure<br>· Removal of tumors and cysts<br>· Correction of congenital anomalies (see reconstructive surgery)<br>· Surgical treatment of morbid obesity<br>· Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.<br>· Voluntary sterilization<br>· Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a).<br>· Treatment of burns | Nothing,<br>included in your per-visit or per-admission copayment |
| *Not covered:*<br>· *Reversal of voluntary sterilization and complications incidental to such procedures*<br>· *Routine treatment of conditions of the foot; see Foot care.* | *All charges.* |

| Reconstructive surgery | You pay |
|---|---|
| · Surgery to correct a functional defect<br>· Surgery to correct a condition caused by injury or illness if:<br>·· the condition produced a major effect on the member's appearance and<br>·· the condition can reasonably be expected to be corrected by such surgery<br>· Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.<br>· All stages of breast reconstruction surgery following a mastectomy, such as:<br>·· surgery to produce a symmetrical appearance on the other breast;<br>·· treatment of any physical complications, such as lymphedemas;<br>·· breast prostheses and surgical bras and replacements (see Prosthetic devices)<br>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. | Nothing,<br>included in your per-visit or per-admission copayment |
| *Not covered:*<br>· *Cosmetic surgery –surgical service performed mainly to improve a person's appearance. However, cosmetic surgery does not include surgical services to correct deformity resulting from disease, trauma, or congenital abnormalities that cause functional impairment, or from a previous therapeutic process.*<br>· *Services related to cosmetic surgery.*<br>· *Surgeries, procedures, services and supplies related to sex transformation* | *All charges* |
| **Oral and maxillofacial surgery** | |
| Oral surgical procedures, limited to:<br>· Surgical correction of congenital defects such as cleft lip and cleft palate;<br>· Dental services needed as a result of an accidental injury that occurred while enrolled with us, and if we approve your plan of treatment submitted within 60 days of the injury;<br>· Preventive dental care to prepare the mouth for radiation therapy to treat head and neck cancer<br>· Medical or surgical procedures that do not involve the teeth or their supporting structures occurring within or adjacent to the oral cavity or sinuses, or related to temporomandibular joint (TMJ) pain dysfunction syndrome | Nothing,<br>included in your per-visit or per-admission copayment |

*continued on next page*

| **Oral and maxillofacial surgery** *(Continued)* | **You pay** |
|---|---|
| *Not covered: All other procedures involving the teeth or areas surrounding the teeth, such as*<br>· *Shortening or lengthening of the mandible or maxillae*<br>· *Dental appliances required to treat TMJ pain dysfunction syndrome or to correct malocclusion or mandibular retrognathia*<br>· *Treatment of natural teeth due to diseases or accidental injury occurring before our effective date of coverage, or for which a treatment plan was not submitted within 60 days*<br>· *Biting and chewing related injuries*<br>· *Restorative services and supplies necessary to repair, remove or replace sound natural teeth*<br>· *Extraction of wisdom teeth* | *All charges.* |
| **Organ/tissue transplants** | |
| Limited to:<br>· Cornea<br>· Heart<br>· Heart/lung<br>· Kidney<br>· Kidney/Pancreas<br>· Liver<br>· Lung: Single –Double<br>· Pancreas<br>· Small bowel<br>· Small bowel-liver transplants<br>· Allogeneic (donor) bone marrow transplants<br>· Autologous bone marrow transplants for (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. | Nothing,<br>included in your per-visit or per-admission copayment |

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| **Organ/tissue transplants** (Continued) | **You pay** |
|---|---|
| · High dose chemotherapy, high dose radiation, and any supporting autologous bone marrow transplants or other forms of autologous stem cell rescue when used to treat certain conditions.<br><br>Note: We cover charges related to the removal of a living organ from a donor and transportation costs. When both the donor and recipient are members of this plan, each is entitled to receive covered services. When only the recipient is a member, both the recipient and the donor are entitled to receive covered services. The donor's benefits are limited to only those not available to the donor from any other source. | Nothing,<br><br>included in your per-visit or per-admission copayment |
| *Not covered:*<br>· *Donor screening tests and donor search expenses for potential donors who are not immediate blood-related family members (parent, child, or sibling).*<br>· *Implants of artificial organs*<br>· *Artificial heart transplants*<br>· *Transplants not listed as covered* | *All charges* |
| **Anesthesia** | |
| Professional services provided in –<br>· Hospital (inpatient)<br>· Hospital outpatient department<br>· Skilled nursing facility<br>· Ambulatory surgical center<br>· Office | Nothing,<br><br>Included in your per-visit or per-admission copayment |

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

IMPORTANT

**Here are some important things to remember about these benefits:**

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

IMPORTANT

| Benefit Description | You pay |
|---|---|
| **Inpatient hospital** | |
| Room and board, such as<br>· ward, semiprivate, or intensive care accommodations (or private room when medically necessary and ordered by a Plan physician);<br>· general nursing care; and<br>· meals and special diets. | $100 per admission |
| Other hospital services and supplies, such as:<br>· Operating, recovery, maternity, and other treatment rooms<br>· Prescribed drugs and medicines<br>· Diagnostic laboratory tests and X-rays<br>· Administration of whole blood, blood, blood plasma, blood derivatives, blood volume expanders, professional donor fees<br>· Dressings, splints, casts, and sterile tray services<br>· Medical supplies and equipment, including oxygen<br>· Anesthetics<br>· Physical therapy, radiation therapy, inhalation therapy, chemotherapy, occupational and speech therapy<br>· Any other medically necessary services as part of inpatient care | Nothing |
| *Not covered:*<br>· *Custodial care*<br>· *Non-covered facilities, such as nursing homes, extended care facilities, schools*<br>· *Personal comfort items, such as telephone, television, barber services, guest meals and beds*<br>· *Private nursing care* | *All charges.* |

| Outpatient hospital or ambulatory surgical center | You pay |
|---|---|
| · Operating, recovery, and other treatment rooms<br>· Prescribed drugs and medicines<br>· Diagnostic laboratory tests, X-rays, and pathology services<br>· Administration of blood, blood plasma, and other biologicals<br>· Blood and blood plasma, if not donated or replaced<br>· Pre-surgical testing<br>· Dressings, casts, and sterile tray services<br>· Medical supplies, including oxygen<br>· Anesthetics and anesthesia service | $50 copayment per visit |
| **Extended care benefits/skilled nursing care facility benefits** | |
| Extended care benefit: The following items and services will be provided to you as an inpatient in a skilled nursing bed or a Plan skilled nursing facility or in a skilled nursing bed in a Plan hospital when we authorize:<br>· Plan Physician visits<br>· Room and board in semi-private accommodations,<br>· Rehabilitative services,<br>· Drugs<br>· Biologicals<br>· Supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies<br>Limited to 100 days per member per illness or condition | Nothing |
| *Not covered: custodial or residential care in a skilled nursing facility or any other facility* | *All charges* |
| **Hospice care** | |
| We cover hospice care we authorize for members diagnosed with a terminal illness with a life expectancy of six months or less. Covered services include the following:<br>· Skilled nursing care<br>· Home infusion therapy drugs for palliative care and pain management<br>· Services of a medical social worker<br>· Services of a home health aide or homemaker<br>· Physical speech or occupational therapy<br>· Durable medical equipment<br>· Routine medical supplies<br>· Routine lab services<br>· Counseling, including nutritional counseling, for to the member's care and death<br>· Bereavement counseling for immediate family members both before and after the member's death<br>· Short-term inpatient care, including respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the member to provide the member's primary caregiver a temporary break. Respite care may be provided only on an intermittent, non-routine and occasional basis and not more than 5 days every 90 days. | Nothing |

*continued on next page*

| **Hospice care** *(Continued)* | **You pay** |
|---|---|
| *Not covered: Independent nursing* | *All charges* |
| **Ambulance** | |
| Local professional ambulance service when medically appropriate, and prearranged and authorized by us. In an emergency, authorization is not required. | Nothing |

## Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

### What is a medical emergency?

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

### What to do in case of emergency:

**Emergencies within our service area:** Medical care is available through your primary care physician 7 days a week, 24 hours a day. For instructions on how to receive care, call your primary care physician, or a nurse advisor at 800/382-9625. If the emergency is such that immediate action is demanded, you should be taken to the nearest appropriate medical facility.

**Emergencies outside our service area:** If an Emergency occurs when you are temporarily outside the service area, you should obtain care at the nearest medical facility. Benefits for continuing or follow-up treatment must be pre-arranged by your primary care physician and provided in the service area.

**Notification:** In the event of an emergency requiring hospitalization, you or your representative must notify us within 48 hours after care is commenced or on the next business day. Failure to do so may result in denial of benefits. This applies to services received within or outside the service area.

**Non-Plan Providers:** We cover services rendered by providers other than Plan providers when the condition treated is an emergency as defined above.

| Benefit Description | You pay |
|---|---|
| **Emergency within our service area** | |
| · Emergency care at a doctor's office<br>· Emergency care at an urgent care center<br>· Emergency care as an outpatient or inpatient at a hospital, including doctors' services | $10 per visit to your primary care physician<br>$20 per visit to a specialist<br>$20 per visit to an urgent care center<br>$50 per visit to a hospital emergency room<br>(waived if admitted) |
| *Not covered: Elective care or non-emergency care* | *All charges.* |

| Emergency outside our service area | You pay |
|---|---|
| · Emergency care at a doctor's office<br>· Emergency care at an urgent care center<br>· Emergency care as an outpatient or inpatient at a hospital, including doctors' services | $10 per visit to a primary care physician<br>$20 per visit to a specialist<br>$20 per visit to an urgent care center<br>$50 per visit to a hospital emergency room<br>(waived if admitted) |
| *Not covered:*<br>· *Elective care or non-emergency care*<br>· *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*<br>· *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* | *All charges.* |
| **Ambulance** | |
| Professional ambulance service when medically appropriate.<br>See 5(c) for non-emergency service. | Nothing |

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

IMPORTANT

**Parity**

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

| Benefit Description | You pay |
|---|---|
| **Mental health and substance abuse benefits** | |
| All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.<br>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. | Your cost sharing responsibilities are no greater than for other illnesses or conditions. |
| · Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers<br>· Medication management | $10 per visit to your primary care physician<br>$20 per visit to a specialist |
| · Diagnostic tests | Nothing if you receive these services during your office visit; otherwise<br>$10 per visit to your primary care physician<br>$20 per visit to a specialist |
| · Services provided by a hospital or other facility<br>· Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment | $100 per admission |

| **Mental health and substance abuse benefits** *(Continued)* | **You pay** |
|---|---|
| *Not covered:*<br>· *Services we have not approved.*<br>· *Methadone maintenance at any level of care*<br>· *Services for biofeedback therapy, smoking or nicotine addition*<br>· *Marital, family, educational or training services*<br>·<br>*Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.* | *All charges.* |

**Preauthorization**

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

A primary care physician referral is not necessary to access mental health/substance abuse services. You, a family member, or your physician may access care directly by calling the mental health toll-free number on your identification card, 800/991-6045. Network providers are listed in our directory, but because HealthKeepers, Inc. networks are subject to change, please call the toll free number to verify that a provider is in the network, to request care, or to obtain referral information.

**Special transitional benefit**

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

· If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

## Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no deductible
- Some drugs and drug therapies require prior authorization. Prior authorization is required for medications approved for restricted uses and quantities that exceed program limitations. Your physician handles the prior authorization process by sending a written request and applicable medical records to our Drug Prior Authorization Unit.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy
- **These are the dispensing limitations:**
  - For each prescription, we will cover up to a 31-day or 100-unit supply, whichever is less.
  - Certain drugs are subject to additional dosage limitations. Because the list is subject to change, you or your physician may contact us for updated dosage limitations.
  - We do not cover quantities of any drug or medication above the recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia, However, we will not deny coverage of prescription drugs used in the treatment of cancer pain on the basis that the dosage exceeds the recommended level, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain. We do not cover drugs and medications not approved by the FDA for the purpose prescribed. However, benefits will not be denied for any drug or medication approved by the FDA for use in the treatment of cancer on the basis that the drug has not been approved by the FDA for the specific type of cancer, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
- **When you have to file a claim.** The many pharmacies that participate in our network are listed in your provider directory and will file claims for you. Any member-submitted claims must be submitted on a Plan Pharmacy claim form, with receipts and a written explanation attached, within 120 days of the date the prescription was filled.

*Prescription drug benefits begin on the next page.*

| Benefit Description | You pay |
|---|---|
| **Covered medications and supplies** | |
| We cover medically necessary prescribed legend drugs (drugs not available over the counter) when prescribed by a Plan physician and obtained from a Plan pharmacy, such as:<br>· Compound medications of which at least 1 ingredient is a legend drug<br>· Growth hormones<br>· Injectable insulin and syringes, and needles for the administration of injectable insulin<br>· Home blood glucose monitors, lancets and blood glucose test strips for members with diabetes<br>· Diaphragms, birth control pills, and other FDA-approved prescription contraceptive drugs and devices<br>· Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below.<br>· Drugs for sexual dysfunction, subject to dosage limitation and prior authorization.<br>· Intravenous fluids and medications for home use and some injectable drugs are covered under Medical and Surgical Benefits | $5 copayment (first tier)<br>$10 copayment (second tier)<br>$25 copayment (third tier) |
| Here are some things to keep in mind about our prescription drug program:<br>· All covered brand name and generic drugs are categorized into three specific tiers and each tier is assigned a copayment level:<br>  · First-tier drug means a low cost prescription drug, typically a generic drug<br>  · Second-tier drug means a moderate cost prescription drug, typically a multi-source brand name drug. A multi-source brand name drug is a brand name drug with a generic equivalent.<br>  · Third-tier drug means a high cost prescription drug, typically a single-source brand name drug. A single-source brand name drug is a brand name drug without a generic equivalent.<br>· We make the determination of whether a particular drug is a first-, second-, or third-tier drug. In exercising our discretion, we will consider a number of factors when classifying drugs into tiers, such as:<br>  · The absolute cost of the drug,<br>  · The relative cost of the drug within its therapeutic class,<br>  · The availability of over the counter alternatives, and<br>  · Certain clinical effectiveness and economic factors.<br>· Generic drugs will be dispensed. You may request a brand name drug and pay the difference between the brand name drug and the generic drug, in addition to your applicable copayment.<br>· We have an open formulary. Our prescription drug coverage gives you access to all brand name and generic drugs within the confines of your benefit design. Unlike closed formularies that restrict individual drugs, your three-tier plan excludes only non-covered classes of drugs listed below. | |

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| **Covered medications and supplies** *(continued)* | **You pay** |
|---|---|
| *Not covered:*<br>· *Drugs and supplies primarily for cosmetic purposes*<br>· *Drugs for weight control*<br>· *Fertility drugs*<br>· *Smoking cessation devices or medications*<br>· *Vitamins and nutritional substances that can be purchased without a prescription*<br>· *Nonprescription medicines* | *All Charges* |

## Section 5 (g). Special Features

| Feature | Description |
|---|---|
| **Individual Case Management** | In addition to the covered services, we may elect to offer benefits for services according to an alternative treatment plan that we approve.<br>· We shall provide such alternative benefits at our sole discretion and only when we determine that the alternative services are medically necessary and cost effective, and that the total benefits paid for such services do not exceed the maximum benefits to which you would otherwise be entitled.<br>· If we elect to provide alternative benefits for a member in one instance, we are not obligated to provide the same or similar benefits for any member in any other instance, nor shall it be construed as a waiver of our right to administer our benefits in strict accordance with its express terms.<br>· Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. |
| **24 hour nurse line** | For any of your health concern, 24 hours a day, 7 days a week, you may call the HealthKeepers Nurse Advisor Line at 1-800-382-9625 and talk with a registered nurse who will discuss treatment options and answer your health questions. |
| **Early Intervention** | We cover early intervention services up to $5,000 per member per calendar year for any combination of services. Early intervention services are the medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for covered dependents from birth to age three. The dependent must be certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act. Medically necessary early intervention services include those designed to help an individual attain or retain the capability to function age-appropriately within his or her environment. It also includes services that enhance functional ability without effecting a cure. |
| **Travel Benefit** | Please see page 6 for a description of *Blues***CONNECT**, the Blue Cross and Blue Shield Health Maintenance Organization national network that expands your coverage to 43 states and the District of Columbia. |

## Clinical Trials for Cancer

The following definitions apply:

"Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH (National Institutes of Health)-approved peer review program operating within the group. "Cooperative group" includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute Community Clinical Oncology Program.

"Multiple project assurance contract" means a contract between an institution and the Federal Department of Health and Human Services that defines the relationship of the institution to the Federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

We cover clinical trials for cancer, including ovarian cancer trials, when the following requirements are met:

- Coverage will be provided if the treatment is being conducted in a Phase II, Phase III or Phase IV clinical trial. Coverage may be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.
- Clinical trials must be approved by one of the following:
  - NCI (National Cancer Institute);
  - An NCI cooperative group or NCI center;
  - The FDA (Federal Food and Drug Administration) in the form of an investigational new drug application;
  - The Federal Department of Veterans Affairs; or
  - An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.
- The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training and expertise.
- Coverage shall be provided only if:
  - There is no clearly superior, non-investigational treatment alternative;
  - The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; and
  - The member and the physician or health care provider who provides services to the member under this paragraph conclude that the member's participation in the clinical trial would be appropriate.
- Coverage does not include the cost of non-health care services, such as travel or lodging, costs associated with managing the research associated with the clinical trial or the cost of the investigational drug or device.

## Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

| Accidental injury benefit | You pay |
|---|---|
| Dental services needed as a result of an accidental injury that occurred while enrolled with us, and if we approve your plan of treatment submitted within 60 days of the injury; | $20 copayment per specialist doctor visit. |

*Not covered:*

- *All other dental services not shown as covered.*
- *Treatment of natural teeth due to diseases or treatment of natural teeth due to accidental injury occurring before our effective date of coverage, or for which a treatment plan was not submitted within 60 days*
- *Biting and chewing related injuries*

### Dental benefits

We have no other dental benefits.

## Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

| | |
|---|---|
| **HealthKeepers Dental Discount Program** | HealthKeepers introduces your brand-new Dental Discount Program. Need a check-up, a crown or filling, or braces? Simply show your Trigon HealthKeepers identification card to a participating dentist to receive a 20% discount off normal fees. Best of all, there are no claim forms to file, and no referral or pre-authorization required. We are pleased to offer this program to you at no additional cost. |
| **Trigon Healthy Complements Program—Discounts on Alternative Therapy, Wellness and Herbals** | Interested in alternative therapies? Your Healthy Complements program links you to healthy discounts of 25% on acupuncture, massage therapy and additional chiropractic services. You even have guaranteed discounts on vitamins, nutritional supplements and other health-related products, with no shipping charges. Want savings on health clubs and fitness centers? No sweat, they're yours! And if you can't tell Gingko from Ginseng, help is a click away. Just log on to www.trigon.com for Health Complements online, your complete alternative health care resource. From aromatherapy to yoga, you'll find it here, all at no additional cost to you. |
| **Expanded Vision Care, including LASIK and PRK Vision Surgery Discounts** | As a Trigon HealthKeepers member, your vision care vendor offers you great discounts on vision services and supplies, including eyewear, contacts and vision correction surgery. You can purchase anything from eyeglasses and sunglasses to contact lenses and lens cleaner. Simply present your Trigon HealthKeepers identification card to receive your discount. This program is available at no additional cost to you. |
| **Support for Managing Ongoing Conditions Means Better Health** | If you or a family member has an ongoing condition—asthma, diabetes, coronary artery disease or congestive heart failure—you know the impact it has on your life. The Trigon Disease Management program brings together the tools needed to successfully manage these conditions. From access to registered nurses 24 hours a day, to self-monitoring tools, to newsletters containing information on the latest updates about your condition, the disease management program can help you stay at your peak. The Trigon HealthKeepers Disease Management Program is available at no additional cost to you. |
| **Baby Benefits Program—C. Everett Koop National Health Award for Healthier Babies** | Expecting? Here's the best baby gift of all—good health—special delivery from your Baby Benefits program. With Baby Benefits, you'll have access to a team of registered nurses who will work closely with you, monitoring your progress and answering your questions to give you the information you need throughout your pregnancy. They are available whenever you need them—24 hours a day, every day. Your nurse counselors will help identify the potential for premature delivery from the earliest signs and get you the help you need to reduce that risk. Throughout your pregnancy, answers, support and resources are available to help make sure your baby is healthy as can be, right from the start. This program is available to the enrollee at no additional cost. |

## Section 6. General exclusions -- things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (See Emergency Benefits);
- Services, drugs, or supplies which are not medically necessary.
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

## Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment. We have no coinsurance or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

### Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 800/421-1880.

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer, such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

**Submit your claims to:**

HealthKeepers, Inc.

P.O. Box 26623

Richmond, VA 23285-0031

### Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

### Prescription drugs

Any member-submitted claims must be submitted on a Plan Pharmacy claim form, with receipts and a written explanation attached, within 120 days of the date the prescription was filled.

**Submit your claims to:**

HealthKeepers, Inc.

P.O. Box 26623

Richmond, VA 23285-0031

### When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

## Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

| Step | Description |
|---|---|
| **1** | Ask us in writing to reconsider our initial decision. You must:<br>(a) Write to us within 6 months from the date of our decision; and<br>(b) Send your request to us at: HealthKeepers, Inc., PO Box 26623, Richmond VA 23285; and<br>(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and<br>(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
| **2** | We have 30 days from the date we receive your request to:<br>(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or<br>(b) Write to you and maintain our denial -- go to step 4; or<br>(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3. |
| **3** | You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.<br>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.<br>We will write to you with our decision. |
| **4** | If you do not agree with our decision, you may ask OPM to review it.<br>You must write to OPM within:<br>· 90 days after the date of our letter upholding our initial decision; or<br>· 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or<br>· 120 days after we asked for additional information.<br>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.<br>Send OPM the following information:<br>· A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;<br>· Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;<br>· Copies of all letters you sent to us about the claim;<br>· Copies of all letters we sent to you about the claim; and<br>· Your daytime phone number and the best time to call.<br>Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim. |

## The disputed claims process *(Continued)*

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800/421-1880 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division III at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

## Section 9. Coordinating benefits with other coverage

**When you have other health coverage**

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

**•What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

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

**•The Original Medicare Plan**

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Primary Care Physician as required.

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

| **Primary Payer Chart** | | |
|---|---|---|
| **A. When either you -- or your covered spouse -- are age 65 or over and …** | **Then the primary payer is…** | |
| | **Original Medicare** | **This Plan** |
| 1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability), | | ✓ |
| 2) Are an annuitant, | ✓ | |
| 3) Are a reemployed annuitant with the Federal government when… | | |
| a) The position is excluded from FEHB, or | ✓ | |
| b) The position is not excluded from FEHB | | ✓ |
| Ask your employing office which of these applies to you. | | |
| 4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge), | ✓ | |
| 5) Are enrolled in Part B only, regardless of your employment status, | ✓ (for Part B services) | ✓ (for other services) |
| 6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty, | ✓ (except for claims related to Workers' Compensation.) | |
| **B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…** | | |
| 1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD, | | ✓ |
| 2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD, | ✓ | |
| 3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision, | ✓ | |
| **C. When you or a covered family member have FEHB and…** | | |
| 1) Are eligible for Medicare based on disability, and | | |
| a) Are an annuitant, or | ✓ | |
| b) Are an active employee | | ✓ |

**Claims process –** Your provider must file a Medicare claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first.

**We waive some costs when you have Medicare –** When Medicare is the primary payer, we will waive our copayment on inpatient hospital admissions. We do not waive any other costs.

**• Medicare managed care plan**

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

**This Plan and another Plan's Medicare managed care plan:** You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments.

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

**• Enrollment in Medicare Part B**

**Note:** If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

## TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

## Workers' Compensation

We do not cover services that:

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

| | |
|---|---|
| | Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers. |
| **Medicaid** | When you have this Plan and Medicaid, we pay first. |
| **When other Government agencies are responsible for your care** | We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them. |

## Section 10. Definitions of terms we use in this brochure

**Calendar year**

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

**Copayment**

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

**Coinsurance**

Coinsurance is the percentage of our allowance that you must pay for your care. We do not have coinsurance

**Covered services**

Care we provide benefits for, as described in this brochure.

**Deductible**

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. We do not have deductibles.

**Experimental/Investigational**

Any service or supply may be determined to be experimental or investigational in the Plan's sole discretion, based on the following four criteria:

1. Any supply or drug must have received final approval to market by the United States Food and Drug Administration;
2. There must be sufficient information in the peer-reviewed medical and scientific literature to enable the Plan to make conclusions about safety and efficacy;
3. The available scientific evidence must demonstrate a beneficial effect on health outcomes outside a research setting; and
4. The service or supply must be as safe and effective outside a research setting as existing diagnostic or therapeutic alternatives.

**Medical necessity**

Medically necessary services mean those covered services that are consistent with the diagnosis and treatment of your condition, are efficacious, are in accordance with standards of good medical practice, are not simply for your or your provider's convenience, and are performed in the most cost-effective setting available to you. We will determine the medical necessity of a given service or procedure.

**Us/We**

Us and we refer to Trigon HealthKeepers, offered by HealthKeepers, Inc.

**You**

You refers to the enrollee and each covered family member.

## Section 11. FEHB facts

### No pre-existing condition limitation

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

### Where you can get information about enrolling in the FEHB Program

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

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

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

### Types of coverage available for you and your family

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

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

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

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

### When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

### Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

· OPM, this Plan, and subcontractors when they administer this contract;

· This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;

· Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;

· OPM and the General Accounting Office when conducting audits;

· Individuals involved in bona fide medical research or education that does not disclose your identity; or

· OPM, when reviewing a disputed claim or defending litigation about a claim.

## When you retire

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

## When you lose benefits

**•When FEHB coverage ends**

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

·· Your enrollment ends, unless you cancel your enrollment, or

·· You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

**• Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

**•TCC**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire.

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

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

**•Converting to individual coverage**

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

·· Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;

·· You decided not to receive coverage under TCC or the spouse equity law; or

·· You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing

coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

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

## Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

## Inspector General Advisory

**Stop health care fraud!** Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/421-1880 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

### Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

# Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

# Summary of benefits for Trigon HealthKeepers, offered by HealthKeepers, Inc. -2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

| Benefits | You Pay | Page |
|---|---|---|
| Medical services provided by physicians:<br>· Diagnostic and treatment services provided in the office ..... | Office visit copay: $10 primary care; $20 specialist | 13 |
| Services provided by a hospital:<br>· Inpatient..... | $100 per admission copay | 24 |
| · Outpatient..... | $50 per visit copay | 25 |
| Emergency benefits:<br>· In-area..... | $50 per emergency room visit | 27 |
| · Out-of-area ..... | $50 per emergency room visit | 28 |
| Mental health and substance abuse treatment ..... | Regular cost sharing | 29 |
| Prescription drugs..... | First tier: $5 copay<br>Second tier: $10 copay<br>Third tier: $25 copay | 31 |
| Dental Care ..... | $20 copay for accidental injury only | 36 |
| Vision Care ..... | $10 copay for annual eye exam, $25 copay for contact lens exam | 17 |
| Special features:<br>· Individual Case Management<br>· 24 Hour Nurse Line<br>· Early Intervention<br>· Travel Benefit<br>· Clinical Trials for Cancer | | 34 |
| Protection against catastrophic costs (your out-of-pocket maximum) ..... | Nothing after $1,500/Self Only or $3,000/Family enrollment per year<br>Some costs do not count toward this protection | 11 |

# 2001 Rate Information for
# Trigon HealthKeepers

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

**Postal rates** apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

| | | Non-Postal Premium | | | | Postal Premium | |
|---|---|---|---|---|---|---|---|
| | | Biweekly | | Monthly | | Biweekly | |
| Type of Enrollment | Code | Gov't Share | Your Share | Gov't Share | Your Share | USPS Share | Your Share |

**Serving:**
**Eastern Virginia,** including the Peninsula, Hampton Roads and Tidewater areas;
**Central Virginia,** including Fredericksburg, Richmond, Charlottesville and Southside areas;
**Western Virginia,** including Roanoke, Lexington, and Bedford areas; and
**Southwestern Virginia,** including the Wytheville and New River Valley areas

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Self Only** | **X81** | **$78.33** | **$26.11** | **$169.72** | **$56.57** | **$92.69** | **$11.75** |
| **Self and Family** | **X82** | **$195.82** | **$69.39** | **$424.28** | **$150.34** | **$231.17** | **$34.04** |