KEYSTONEBLUE
A Blue Cross and Blue Shield HMO
from Keystone Health Plan West

Keystone Health Plan West Is an Independent Licensee of the Blue Cross and Blue Shield Association

KeystoneBlue

http://www.highmark.com

2002

A Health Maintenance Organization

Serving: The Pittsburgh, Altoona and Erie, Pennsylvania areas

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

This Plan has commendable accreditation from the NCQA. See the 2002 Guide for more information on accreditation.

Enrollment codes for this Plan:

EF1 Self Only
EF2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

RI 73-484

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Introduction

Keystone Health Plan West, Inc., d.b.a. KeystoneBlue
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222

This brochure describes the benefits of KeystoneBlue under its contract (CS2340) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means KeystoneBlue.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW, Washington, DC 20415.

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 1-800/421-0959 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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 identification card if the person tries to obtain services for a person 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.

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, and coinsurance 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?

KeystoneBlue is an Individual Practice Prepayment (IPP) model HMO, offering you a choice of more than 2,600 primary care doctors. Federal employees, annuitants, and their dependents enrolled in this Plan will need to select a personal doctor from a list of our participating primary care doctors. A primary care doctor is a doctor who has been specially trained in the areas of Family Practice, General Practice, Internal Medicine, or Pediatrics.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you.

If you want more information about us call 1-800/421-0959, or write to KeystoneBlue, 1800 Center Street, P.O. Box 890037, Camp Hill, PA 17089-0037, or visit our website at www.highmark.com.

Service Area

To enroll in our Plan, you must live or work in our Service Area. This is where our providers practice. Our service area is **Western Pennsylvania** which includes the following areas:

Greater Pittsburgh: The Pennsylvania counties of Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Lawrence, Washington and Westmoreland.

Erie: The Pennsylvania counties of Clarion, Crawford, Erie, Forest, McKean, Mercer and Venango.

Altoona: The Pennsylvania counties of Bedford, Blair, Cambria, Cameron, Clearfield, Elk, Huntingdon, Indiana, Jefferson, Potter, Somerset and Warren.

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

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2002

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

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- Your share of the non-Postal premium will increase by 71.9% for Self Only or 56.5% for Self and Family
- We now cover certain intestinal transplants; islet cell autotransplantation; and multivisceral transplantation, which includes the small bowel with or without the liver and one or more of the following: stomach, duodenum, jejunum, ileum, pancreas, and colon. (Section 5(b))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))

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 1-800/421-0959.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments or coinsurance and you will not have to file claims.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our 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 to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You can choose a primary care physician from our provider directory or from our website.

- **Primary care**

Your primary care physician can be a family practitioner, internist, pediatrician, general practitioner, etc. 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. For most types of specialty care, the referred specialist can provide necessary follow-up care for up to 60 days, if needed, without an additional referral from your primary care physician. Any continued treatment beyond this 60-day period needs to be authorized by your primary care physician. However, women may see a network gynecologist or network nurse midwife for obstetrical or gynecological care without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

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

- 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 1-800/421-0959. 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 benefits of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. Care received outside of our network, except for emergency care, is not covered. Elective care received outside our network is not covered.

We call this review and approval process Prior Plan Approval. Your physician must obtain Prior Plan Approval for the following services: Assisted fertilization procedures; Cardiac Rehabilitation; Durable medical equipment (DME), Orthopedic and Prosthetic devices, and Respiratory equipment and supplies; Enteral formulae; Home health aides; Physical, speech, and occupational therapy; growth hormone therapy (GHT); and Hysterectomy, Appendectomy, and back surgeries, etc.

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, facility, pharmacy, etc., when you receive services. Example: When you see your primary care physician you pay a copayment of $10 per office visit. When you go in the hospital, you pay $100 per admission, limited to three inpatient hospital copayments per individual, and up to five inpatient hospital copayments per family, per calendar year.
• **Deductible**	We do not have a deductible. Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.
• **Coinsurance**	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our Plan, you pay up to $200 or 50% of the cost, whichever is less, for infertility services.
Your catastrophic protection out-of-pocket maximum for coinsurance and copayments	We do not have an out-of-pocket maximum, except for a $300 per individual and $500 per family inpatient hospital copayment limit.

Section 5. Benefits — OVERVIEW

(See page 8 for how our benefits changed this year and page 55 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 1-800/421-0959 or at our website at www.highmark.com.

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.
- 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 • In physician's office • Office medical consultation • Second surgical opinion	$10 per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility	Nothing
At home	$10 per visit
Not covered: Charges for missed appointments.	*All charges.*

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing when authorized by a Plan primary care physician or specialist.
Preventive care, adult	
Routine screenings, such as: • Routine physical exams • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including — Fecal occult blood test — Sigmoidoscopy, screening – every five years starting at age 50 • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office visit; no separate copayment for routine screenings.
• Routine pap test	Nothing
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 and over, one every calendar year • Screening regardless of age when prescribed by your primary care physician or obstetrician/gynecologist.	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or immunizations for foreign travel, licensing, premarital or sports.	*All charges.*

Preventive care, adult ***(continued)***	**You pay**
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine — annually, age 50 and over — annually, for person at high risk, between ages 18 and 64 • Pneumococcal vaccine — annually, age 65 and over — annually, for person at high risk, between ages 18 and 64	$10 per office visit; no separate copayment for routine immunizations.
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit; no separate copayment for routine immunizations.
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: — Eye exams through age 17 when performed by primary care physician to determine the need for vision correction. — Ear exams through age 17 when performed by primary care physician to determine the need for hearing correction. — Examinations done on the day of immunizations (up to age 22)	$10 per office visit; no separate copayment for preventive care screenings.
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • 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. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.	Nothing. Copayments are waived for maternity care.

Maternity care *(continued)*	**You pay**
• Coverage is provided for one (1) maternity home health care visit, within 48 hours of discharge when the discharge occurs prior to 48 hours of inpatient care following a normal vaginal delivery, or 96 hours of inpatient care following a cesarean delivery. • 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. Copayments are waived for maternity care.
Not covered: Routine sonograms to determine fetal age, size or sex.	*All charges.*
Family planning	
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$10 per office visit; no separate copayment for listed services.
Not covered: reversal of voluntary surgical sterilization, genetic counseling.	*All charges.*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: — intravaginal insemination (IVI) — intracervical insemination (ICI) — intrauterine insemination (IUI) • Fertility drugs • Cost of donor sperm Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	Up to $200 or 50% of the cost, whichever is less. These services, including fertility drugs, require prior authorization by the Plan.
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* *— in vitro fertilization* *— embryo transfer, gamete GIFT and zygote ZIFT* *— Zygote transfer* • *Medical services and supplies related to excluded ART procedures* • *Cost of donor egg*	*All charges.*

Allergy care	You pay
Testing and treatment • Allergy injection • Allergy serum	$10 per office visit; no separate copayment for testing, injections or serum.
Not covered: Provocative food testing, and sublingual allergy desensitization.	*All charges.*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on pages 26-27. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Enteral formulae administered on an outpatient basis either orally or through a tube • Growth hormone therapy (GHT) Note: Growth hormones are covered under the prescription drug benefit. We will only cover Enteral formulae and GHT when we preauthorize treatment.	$10 per office visit to specialist; no separate copayment for treatment therapies.
Not covered: • *Hair growth stimulants* • *Hair replacements and hair replacement surgery* • *Weight reduction programs, except when medically necessary for morbid obesity*	*All charges.*
Physical and occupational therapies	
• 60 days per condition for the services of each of the following: — qualified physical therapists; — occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is covered at a Plan facility for up to 12 weeks	Nothing
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*

Speech therapy	You pay
• 60 days per condition for the services of qualified speech therapists.	Nothing
Hearing services (testing, treatment, and supplies)	
• Diagnostic hearing test when medically necessary • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit; no separate copayment for hearing screenings
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Note: See *Preventive care, children* for eye exams for children	$10 per office visit
The following benefits are provided through OptiChoice™, our Preferred Vision Care Program. The OptiChoice In-Network Annual Vision Benefits Program offers affordability and paid-in-full vision benefits on standard, eligible services. It also offers a quality network of statewide and national vision care providers who agree to accept program allowances as payment in full, in accordance with the OptiChoice benefit design. Members are required to select an optometrist, ophthalmologist, or optical supplier from the Preferred Provider Network. You can get information by calling 1-800/541-2039. **Payment for services is limited to in-network only and services are eligible once a year.** It also provides discounts on additional examinations, frames, lenses, contacts, optical accessories, and supplies. There is no pre-authorization or deductible required. OptiChoice Preferred Providers submit claims for members and receive direct reimbursement, completely removing members from the paperwork process. Following is a summary of benefits and out-of-pocket expenses.	
• Eye Examination and Refractive Service • Contact Lens Prescription Fitting	Nothing

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

Vision services (testing, treatment, and supplies) ***(continued)***	**You pay**
Post Refractive Services • Frames	All charges in excess of $60
Post Refractive Services • Single Vision Lenses (Standard) • Bifocal Vision Lenses (Standard) • Trifocal Vision Lenses (Standard) • Aphakic Vision Lenses (Standard)	Nothing
Post Refractive Services: • Single Vision Lenses (Non-standard) • Bifocal Vision Lenses (Non-standard) • Trifocal Vision Lenses (Non-standard) • Aphakic/Lenticular Vision Lenses (Non-standard)	90% of the difference between the normal charge and the non-standard charge for the same type of standard lenses.
Post Refractive Services: • Hard Contact Lenses (Standard) • Soft Contact Lenses (Standard)	Nothing
Post Refractive Services: • Specialty Contact Lenses (Standard)	All charges in excess of $75.
Post Refractive Services: • Vision Care Options (tints, contact lens solutions, etc.)	The cost of the items less a 10% discount.
Post Refractive Services: • Additional Post-Refractive Services	All charges in excess of the Program's Allowance.
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy*	*All charges.*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; lenses following cataract removal; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Braces • Shoes permanently attached to a brace • Custom molded foot orthotics	$10 per office visit
Not covered: • *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses and other supportive devices*	*All charges.*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Standard hospital beds; • Standard wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; • Insulin pumps, and • Motorized wheel chairs if authorized and medically necessary Note: Call us at 1-800/421-0959 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	Nothing
Not covered: • *Motorized wheelchairs that are not authorized and not medically necessary* • *Electric hospital beds*	*All charges.*
Home health services	
• Home health care ordered by your primary care physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative;* • *Homemaker services, and* • *Food or home delivered meals*	*All charges.*
Chiropractic	
• Limited to spinal manipulation	Nothing

Alternative treatments	You pay
Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief.	$10 per office visit
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges.*
Educational classes and programs	
Coverage includes, but is not limited to: • Diabetes self-management • Congestive heart failure self-management • Chronic obstructive pulmonary disease (COPD) self-management • Smoking cessation class (see Section 5(i))	Nothing

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.
- 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. Any costs associated with the facility charge (i.e. hospital, surgical center, etc.) are covered in Section 5 (c).
- YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR ALL INPATIENT PROCEDURES AND SOME OUTPATIENT SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity — a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing

Surgical procedures — continued on next page.

Surgical procedures ***(continued)***	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.* • *Correction of myopia or hyperopia by means of corneal microsurgery such as keratomileusis, keratophakia and radial keratotomy*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: — the condition produced a major effect on the member's appearance and — the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: — surgery to produce a symmetrical appearance on the other breast; — treatment of any physical complications, such as lymphedemas; — breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Member is eligible for 1 (one) home health care visit, as determined by the member's physician and received within 48 hours after discharge. The discharge must occur within 48 hours after the admission for a mastectomy.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges.*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Procedures adjacent to the oral cavity or sinuses (such as excision of tumors and cysts); • Extractions of impacted third molars when partially or totally covered by bone; • Extraction of teeth in preparation for radiation therapy, and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental care involving temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges.*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single-Double • Pancreas • Skin and tissue • Small bowel • Small bowel/liver • Multivisceral which includes the small bowel with or without the liver and one or more of the following: stomach, duodenum, jejunum, ileum, pancreas and colon. • Islet cell autotransplantation • Allogeneic (donor) bone marrow transplants	Nothing

Organ/tissue transplants — continued on next page.

Organ/tissue transplants *(continued)*	**You pay**
• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. Limited Benefits — Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges.*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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 Sections 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	$100 copay per admission up to a maximum of $300 per individual and $500 per family per calendar year.

Inpatient hospital — continued on next page.

Inpatient hospital ***(continued)***	**You pay**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Storage of blood, except when done in preparation for a scheduled surgical procedure.*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: • *Storage of blood, except when done in preparation for a scheduled surgical procedure*	*All charges.*

Extended care benefits/skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): The Plan provides a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor. All necessary services are covered including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing
Not covered: custodial care	*All charges.*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: Independent nursing, homemaker services	*All charges.*
Ambulance	
• Local professional ambulance service when medically appropriate and ordered or authorized by a Plan doctor.	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.
- 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 injury that you believe endangers your life, including a pregnant woman or her unborn child, 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: In the event that you or a covered dependent requires emergency care, all charges for such covered services will be paid. No prior authorization is required for emergency care. Either the member or a family member should, if possible, notify the Primary Care Physician within 48 hours of the emergency care or as soon as reasonably possible to facilitate follow-up care.

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

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

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

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

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

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

Emergency benefits begin on the next page

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

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

IMPORTANT

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.
- 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. 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, individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit

Mental health and substance abuse benefits — continued on next page.

Mental health and substance abuse benefits *(continued)*	You pay
• Diagnostic tests	$10 per specialist office visit; no separate copayment for diagnostic tests.
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization and substance abuse residential treatment facilities	$100 copay per admission up to a maximum of $300 per individual and $500 per family per calendar year
Not covered: Services we have not approved Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	*All charges.*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow the network authorization process:

- You must obtain approval from our mental health administrators prior to treatment for any mental health or substance abuse condition. Please call 1-800/258-9808, for preauthorization.

Limitation

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

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.
- 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 Plan or referral doctor or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy or by mail for a maintenance medication.
- **We use a formulary.** The formulary is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copay listed on page 36.

  We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800/421-0959.
- **These are the dispensing limitations:**

  Prescription drugs prescribed by a Plan or referral doctor or licensed dentist and filled at a Plan pharmacy will be dispensed for up to a maximum 34-day supply. Generic drugs may be dispensed when substitution is permissible.

  When generic drugs are available and the prescribing doctor requires the use of a name brand drug, you will pay a higher copayment per prescription or refill.

  When generic drugs are available and the prescribing doctor does not require the use of a name brand drug, but you request the name brand drug, you will pay a higher copayment per prescription or refill, plus the price difference between the generic and name brand drug.

  A mail order program is available to provide up to a 90-day supply of maintenance drugs. For more information on mail order prescription drugs call 1-800/903-6228.

  If you attempt to refill a prescription too soon, it will be denied; however, your pharmacist will be given the eligible date for refill and will pass that information on to you. If your supply has run out because your doctor increased your dosage, your doctor must write a new prescription to cover the increased amounts.

Continued on next page.

Important features you should be aware of *(continued):*

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive name brand drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original name brand product. Generics cost less than the equivalent name brand product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as name brand drugs.

  You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money.

- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic

- **When you have to file a claim.** Mail your completed form and receipts to: Paid Prescriptions, LLC, P.O. Box 1258, Lees Summit, MO 64063-8258. Please complete a separate form for each covered person. You can obtain a claim form by calling Member Service at 1-800/421-0959.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan or referral physician, or licensed dentist, and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • All FDA approved contraceptive drugs. (Up to a three-cycle supply of oral contraceptive drugs may be obtained for a single copayment charge through the mail order program) • Insulin • Insulin syringes, needles, and/or disposable diabetic testing materials; supplies will be included under the same copayment as the insulin • Disposable needles and syringes needed to inject covered prescribed medication • Prenatal vitamins • Fluoride vitamins • Fertility drugs (require prior authorization by the Plan) • Drugs for sexual dysfunction are subject to dosage limits set by the Plan. Contact the Plan for details. • Intravenous fluids and medications for home use and some covered injectable drugs are covered under home health services at no charge • Growth Hormone Therapy requires prior authorization by the Plan • FDA approved drugs to assist with smoking cessation	Retail pharmacy for up to a 34-day supply: $8 copay for generic drugs $14 copay for physician required use of name brand drugs Mail order pharmacy for up to a 90-day supply for maintenance medications for a single copay: $8 copay for generic drugs $14 copay for physician required use of name brand drugs Note: If there is no generic equivalent available, you will still have to pay the $14 name brand copayment. If generic drug is available but you request a name brand drug you pay the $14 name brand copay **plus** the difference between the generic and name brand drug.

Prescription drug benefits — continued on next page.

Covered medications and supplies ***(continued)***	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, and nutritional supplements that can be purchased without a prescription, except for enteral formulae (See above and Section 5(a) Treatment therapies)* • *Nonprescription medicines and over-the-counter drugs* • *Weight loss drugs, except when medically necessary in the treatment of Morbid Obesity* • *Drugs obtained at a non-Plan pharmacy except out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance*	*All charges.*

Section 5 (g). Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Reciprocity benefit/travel	**Obtaining care while away from home:** If you are away from home, you can obtain urgent and follow-up care through the Blue Cross Blue Shield Association's BlueCard program. The BlueCard program, gives you access to the largest network of providers in the United States. The benefits are the same as if you were receiving care at home. If you have an unexpected illness or injury that cannot wait to be treated until you return home, you can arrange urgent care by calling the BlueCard Provider Finder number at 1-800/810-BLUE; it is available 24 hours a day. You will be given the names of three local Blue Cross Blue Shield participating physicians you can call to schedule an appointment that is convenient for you. You can also find a provider online at www.bcbs.com. You do not need to contact your primary care physician for the urgent visit. However, if the out-of-area physician you seek care from recommends any additional visits or refers you to another physician or facility for other services, *you must coordinate this subsequent care with your primary care physician before receiving services.* On-going routine services (follow-up care) that you require when you are away from home must be coordinated with your primary care physician prior to leaving. You can arrange follow-up care through the same process as urgent care and make your appointment at a time and place that is convenient for you. You can also obtain services outside the U.S. by contacting BlueCard Worldwide. Call Member Service at 1-800/421-0959 for information or logon to www.bcbs.com to access the BlueCard Worldwide data base.

Section 5 (g). Special Features

Reciprocity benefit/travel ***(continued)***	***Note: The procedure for emergency services has not changed. When you need emergency services, you should seek care immediately and coordinate any needed follow-up care with your primary care physician. You do not need to call your primary care physician or the BlueCard telephone number before seeking emergency care.*** Your reciprocity benefit also includes a guest membership feature. This feature is for members who will be living outside western Pennsylvania for an extended period of time (for example, a child away at school or when business takes you temporarily to another location.) Through this program, you can apply for a guest membership in another area of the country that has a Blue Cross and Blue Shield HMO plan. The guest membership is designed to serve members who plan to be out of the KeystoneBlue area for 90 to 180 days. The temporary residence can be for either work-related or personal reasons. Your dependents covered by KeystoneBlue can also apply for an unlimited length of time, as long as the application is renewed yearly. As a guest member of another "Blue" HMO plan, you or your dependents would choose a primary care doctor at that plan and have the benefits offered by that HMO. For care coordinated by that plan's primary care physician, you would be responsible only for any applicable copayments or deductibles for that HMO. You need to apply for a guest membership at least 30 days before you would like the guest membership to become effective.

Section 5 (h). Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing
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.

KeystoneBlue also offers members these Distinct Health Enhancement Opportunities:

• ***Dental coverage***
All KeystoneBlue members may take advantage of special discounts through our Healthy Lifestyle Program. By simply presenting your Plan ID card at participating Healthy Lifestyle providers you will receive a 10% to 30% discount off the cost of most dental services. Some dental providers also offer KeystoneBlue members free or discounted initial exams, x-rays, and cleanings.

• ***Healthy Lifestyle Programs***
All KeystoneBlue members may take advantage of discounts available at more than 500 area establishments which promote "healthy lifestyle" choices. By simply presenting your KeystoneBlue membership card at the time of purchase at participating establishments, you may take advantage of discounts on health club memberships, sporting goods, fitness equipment, and nutritional items.

Also, KeystoneBlue members may take advantage of free lifestyle improvement classes on such topics as nutrition and weight loss, smoking cessation, stress management, and prepared childbirth. These classes are offered at least three times a year at various locations in the Western Pennsylvania area.

• ***Blues On Call℠ 1-888/BLUE-428***
Blues On Call provides all KeystoneBlue members with 24-hour access 7 days a week to health information and personalized support for health decisions. The program helps you get more involved in your care by providing a reliable source for current medical information. Blues On Call promotes the philosophy of Shared Decision Making by helping you share with your physicians in the task of choosing treatment options that take into account your values and preferences. Blues On Call also supports physicians by encouraging patient adherence to treatment plans. Enhanced Blues On Call integrates the previously offered services with disease management to provide a comprehensive approach to total patient care. This integration supports overall patient management and will allow members access to services through one source, regardless of the condition that they have.

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 and we agree, as discussed under *What Services Require Our Prior Approval* on page 11.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies *(see Emergency benefits);*
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; 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 fill your prescription drugs at Plan pharmacies you will not have to file claims. Just present your ID card and pay your copayments or coinsurance.

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 1-800/421-0959.

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

Submit your claims to: KeystoneBlue, 1800 Center Street, P.O. Box 890037, Camp Hill, PA 17089-0037

Prescription drugs

Mail your completed form and receipts to: Paid Prescriptions, LLC, P.O. Box 1258, Lees Summit, MO 64063-8258. Please complete a separate form for each covered person. You can obtain a claim form by calling Member Service at 1-800/421-0959.

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 you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny 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: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Keystone Health Plan West, Member Grievance and Appeal Department, P.O. Box 2717, Pittsburgh, PA 15230. (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial — go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request — go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, D.C. 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

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

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

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

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 or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800/421-0959 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 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800/MEDICARE for more information.

— Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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 show how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

- **The Original Medicare Plan (Part A or Part B)**

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

(Primary payer chart begins on next page.)

The following chart illustrates whether **the Original Medicare Plan** 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, or		√
c) Are a former spouse of an annuitant, or	√	
d) Are a former spouse of an active employee		√

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

We will not waive any of our copayments or coinsurance.

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically. We will process your claims for secondary payment based on usual and customary allowances, rather than Medicare allowances. If there is a remaining balance, an explanation of benefits will be sent to you detailing how the claim was processed and showing you any amounts that are your responsibility. To find out if you need to do something about filing your claims, call us at 1-800/421-0959.

We do not waive any costs when you have Medicare.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your 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 provide all the benefits that Original Medicare covers. 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 our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB coverage.

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, or coinsurance. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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 to your 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 managed care plan's service area.

• If you do not enroll in Medicare Part A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person or organization, you must reimburse us for all expenses we paid. This is called subrogation. We will cover the cost of treatment based on your benefit plan, but we do have the right to be repaid from the money that you received in the settlement.

If you do not seek damages, we can attempt to recover the benefits we paid on your behalf. You may be asked to assist us in our recovery efforts. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Covered services

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

Experimental or Investigational services

The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) that is not determined by the Plan or its Designated Agent to be medically effective for the condition being treated. The Plan or its Designated Agent will consider an intervention to be Experimental/Investigative if:

- The intervention does not have FDA approval to market for the specific relevant indication(s); or
- Available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or
- The intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or
- The intervention is not proven to be applicable outside the research setting. If an intervention as defined above is determined to be Experimental/Investigative at the time of service, it will not receive retroactive coverage if, at some future date, medical opinion changes.

Medically necessary and appropriate

Those services or medical supplies that based on the opinion of your primary care physician and/or KeystoneBlue, are determined to be:

- Appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease, or injury; and
- Provided for the diagnosis, or the direct care and treatment of your condition, illness, disease, or injury; and
- In accordance with standards of good medical practice; and
- Not primarily for your convenience, or your provider; and
- The most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered or your condition, and that you cannot receive safe or adequate care as an outpatient.

Us/We

Us and we refer to KeystoneBlue

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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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.

• Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, *the Guide to Federal 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. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB website (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG!*
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. It can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8-hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the *"Not covered"* blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002. Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of benefits for the KeystoneBlue – 2002

- **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: • Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	14
Services provided by a hospital: • Inpatient	$100 copay per admission up to a maximum of $300 per individual and $500 per family per calendar year	28
• Outpatient	Nothing	29
Emergency benefits: • In-area	$50 copay per visit (waived if admitted)	32
• Out-of-area.	$50 copay per visit (waived if admitted)	32
Mental health and substance abuse treatment	Regular cost sharing	33
Prescription drugs . . . . . Up to a 34-day supply per prescription unit or refill. Up to a 90-day supply for maintenance drugs through mail order.	Retail Pharmacy: $8 copay for generic drugs; $14 copay for name brand drugs. Mail Order (Maintenance drugs only): $8 copay for generic drugs; $14 copay for name brand drugs.	35
Dental Care. . . . . Accidental injury benefit only.	Nothing	39
Vision Care. . . . . OptiChoice™ In-Network Annual Benefits Program	Nothing for most standard services	19
Special features: Flexible benefits option; Reciprocity benefit/travel	Nothing	38
Protection against catastrophic costs (your out-of-pocket maximum)	We have no out-of-pocket maximum, except for a $300 per individual and $500 per family inpatient hospital copayment limit.	12

2002 Rate Information for

KeystoneBlue

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
Self Only	EF1	$97.86	$47.63	$212.03	$103.20	$115.52	$29.97
Self and Family	EF2	$223.41	$208.21	$484.06	$451.12	$263.75	$167.87