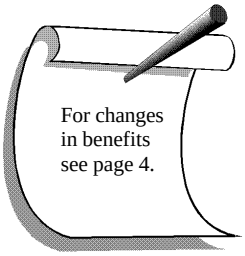
Trigon HealthKeepers
Offered by HealthKeepers, Inc.

Trigon HealthKeepers 2000

A Health Maintenance Organization



Serving: The Peninsula, Southside Hampton Roads, Richmond, Fredericksburg, Charlottesville, Roanoke, and the New River Valley areas, Virginia

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

Enrollment code:
X81 Self Only
X82 Self and Family

This Plan has a commendable status from the NCQA. See the *2000 Guide* for more information on NCQA.

Visit the OPM website at http://www.opm.gov/insure
and
our website at http://www.trigon.com

Authorized for distribution by the:

FEHB
Federal Employees
Health Benefits Program

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Introduction

Trigon HealthKeepers, offered by HealthKeepers, Inc.
P.O. Box 26623
Richmond, VA 23285-0031

This brochure describes the benefits you can receive from HealthKeepers, Inc. under its contract (CS 2091) 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 on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 4. Premiums are listed at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and under-standable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to HealthKeepers, Inc. as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to Use This Brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.
4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.
7. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.
8. FEHB FACTS. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services, 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 or group of physicians, hospital, or other provider will be available and/or remain under contract with us. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How We Change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program (See Section 3, How to get benefits, for more information).

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

Your share of Trigon HealthKeepers' non-postal premium will **decrease** by 31.8% for Self Only or 46.6% for Self and Family.

Clinical trials for cancer, including ovarian cancer trials, are covered when certain requirements are met.

Coverage is added for diabetic lancets under the prescription drug benefit. Previously, coverage was excluded.

Chiropractic services will be covered, when authorized and provided by the Plan's designated provider for this service listed in the Directory of Providers. You pay a $10 copayment per visit and you are limited to 20 visits per member per calendar year. Previously, coverage was excluded.

Hospice care benefits have been added. Previously, there was no specific benefit.

The prescription drug benefit is changed to a three-tier benefit. You pay a $5 copay (first tier), a $10 copay (second tier), or a $25 copay (third tier) per prescription unit or refill. Previously, the prescription drug benefit copay was $5 (generic) or $10 (brand name).

Vision care benefits are expanded to cover one eye refraction every year regardless of age when received from the Plan's vision care vendor. You pay a $10 copay per visit. Previously, eye refractions were limited to one per year for members under age 19 and one every two years for members over age 19. Previously, members over age 19 were covered only for one refraction every two years and the copay for all refractions was $5 per visit.

Section 3. How to Get Benefits

What is this Plan's service area?

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is the entire Hampton Roads area (both the Peninsula and Southside/Tidewater), the Richmond area, the Fredericksburg area, the Charlottesville area, the Roanoke area, and the New River Valley area of Virginia. Our service area is:

The Virginia Cities of:

Charlottesville	Norfolk	Salem
Chesapeake	Petersburg	Suffolk
Colonial Heights	Poquoson	Virginia Beach
Fredericksburg	Portsmouth	Williamsburg
Hampton	Radford	
Hopewell	Richmond	
Newport News	Roanoke	

The Virginia Counties of:

Albemarle	Greene	New Kent
Amelia	Hanover	Nottoway
Botetourt	Henrico	Orange
Caroline	Isle of Wright	Powhatan
Charles City	James City	Prince Edward
Chesterfield	King and Queen	Prince George
Craig	King George	Pulaski
Cumberland	King William	Richmond
Windiddie	Louisa	Roanoke
Essex	Lunenburg	Spotsylvania
Fluvanna	Madison	Stafford
Franklin	Mathews	Surry
Giles	Middlesex	Sussex
Gloucester	Montgomery	Westmoreland
Goochland	Nelson	York

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. We will not pay for any other health care services.

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.

The Trigon HealthKeepers service area is the area in which HealthKeepers, Inc.is licensed to sell Trigon HealthKeepers coverage. If you are traveling outside of the service area and have an unexpected illness or injury requiring immediate attention, you can access your benefits by calling HMO Blue USA at the number on your ID card. The coordinator will put you in touch with an affiliated Blue Cross and Blue Shield HMO near your location, and they will help you find a participating physician. You will not be required to pay the provider when he or she renders the service; however, you will be responsible for your urgent care copayment when you return home. Certain types of elective care such as routine allergy shots or having a full-term baby are not covered when they can be reasonably foreseen before traveling outside the service area.

Trigon HealthKeepers gives you and your covered dependents the flexibility to become Guest Members of an affiliated Blue Cross Blue Shield HMO when staying outside the Trigon HealthKeepers service area for at least 90 days. To join, contact our Member Services Department for a Guest Membership application. An "Away From Home" coordinator will make all the necessary arrangements for you or your dependents to access your Trigon HealthKeepers benefits while away from home. A special Guest Membership ID card will besent to you for your dependents to use when medical care is needed.

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

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services, except for routine prenatal and postnatal office visits for maternity care

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After you pay $1,500 in copayments or coinsurance for one family member, or $3,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the calendar year. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs, dental services, vision care, chiropractic services or outpatient mental health and substance abuse services do not count toward these limits and you must continue to make these payments.

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

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

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

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 1-800/421-1880, or in the Richmond area at 358-7390. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist. Services of other providers are covered only when there has been a referral authorized by the member's primary care doctor, with the exception of all services (except inpatient hospital services and outpatient surgery) received from a Plan participating obstetrician-gynecologist in the care of or related to the female reproductive system and breasts.

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. Your primary care physician will get authorization or approval beforehand.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide 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.

What do I do if my 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.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

How do you decide if a service is experimental or investigational?

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

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

Section 4. What to Do if We Deny Your Claim or Request for Service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing;
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information.

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us at 800-421-1880 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contracts Division 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we Uphold our initial denial or refusal of service. You may also ask OPM to review your your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the Following information:

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

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

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to OPM?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division III, P.O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects From you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

Medical and Surgical Benefits

What is covered

Plan doctors and other Plan providers provide a comprehensive range of preventive, diagnostic and treatment services. This includes all necessary office visits; **you pay** a $10 primary care doctor office visit copay and a $20 copay for authorized specialty care doctor office visits, but no additional copay for laboratory tests and x-rays when provided at this visit. Within the service area, house calls will be provided if, in the judgment of the Plan doctor, such care is necessary and appropriate; **you pay** a $20 copay for a doctor's house call and nothing for home visits by nurses and health aides. You pay a $20 copay for outpatient surgery received in a doctor's office other than that of the primary care doctor and a $50 copay for outpatient surgery received in a freestanding or hospital based center.

The following services are included and subject to the office visit copay unless stated otherwise:

- Preventive services: The following preventive health services are covered. Except as noted, your primary care doctor must perform all preventive services.
  1. Well-Child care from birth
  2. Periodic health assessments for adults and children, including screening x-rays, laboratory services, digital rectal examinations, flexible sigmoidoscopies, Prostate Specific Antigen (PSA) tests and immunizations in accordance with recommendations of the American College of Physicians and the American Academy of Pediatrics so long as they are consistent with accepted medical practices as determined by the HMO.
  3. Mammograms as ordered by an HMO physician and no less frequently than the following:
     - One screening mammogram for a member age 35 through 39;
     - Once screening mammogram every other year for a member age 40 through 49; and
     - One screening mammogram annually for a member age 50 and over.

     No primary care doctor referral is necessary for a member to obtain a mammogram.
  4. Vision and hearing screening when performed by your primary care doctor for members up to age 18.
  5. An annual gynecological examination, which consists of a breast exam, pelvic exam and annual testing performed by any FDA-approved gynecologic cytology screening technologies, including Pap smears, is covered for female Members when performed by Your Primary Care Physician or an obstetrician-gynecologist who is an HMO Physician. No Primary Care Physician referral is necessary.

- Health Education: health education services are covered when authorized or furnished by the Plan. This includes outpatient self-management training and education therapy, including medical nutrition therapy, furnished to Members with diabetes.
- Consultations by specialists, when authorized by your primary care doctor.
- X-ray and Laboratory: All x-ray and laboratory tests, services, and materials, including diagnostic x-rays, x-ray therapy, mammography, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests, and therapeutic radiology services are provided when authorized in advance by your primary care doctor and performed by the designated HMO providers for these covered services.
- Maternity Care: Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. Copays apply only to any diagnostic testing, such as ultrasounds, stress tests and amniocentesis. Copays are waived for routine prenatal and postnatal office visits. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Family Planning: Voluntary family planning services authorized by your primary care doctor are provided. Covered services include tubal ligations and vasectomies, prescription contraceptive devices and birth control pills as covered by your prescription drug benefit.
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Organ and Tissue Transplants: Cornea, heart, heart/lung, kidney, liver, lung (single or double), pancreas, pancreas/kidney, small bowel and small bowel/liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for homozygous sickle cell anemia, acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, breast cancer, multiple myeloma, and epithelial ovarian cancer. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Mastectomies: Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis

- Chemotherapy, radiation therapy, and inhalation therapy
- Cardiac rehabilitation therapy, as medically necessary when performed by a Plan provider and authorized by the Plan.
- Surgical treatment of morbid obesity
- Treatment for sleep disorders
- Home health services of a licensed health care profession on a part-time or intermittent basis, including intravenous fluids and medications, when authorized by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you.
- Clinical trials for cancer: The following definitions apply:
  "Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH (National Institutes of Health)-approved peer review program operating within the group. "Cooperative group" includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute Community Clinical Oncology Program. "Multiple project assurance contract" means a contract between an institution and the Federal Department of Health and Human Services that defines the relationship of the institution to the Federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

  The Plan will cover clinical trials for cancer, including ovarian cancer trials, when the following requirements are met:
  - Coverage will be provided if the treatment is being conducted in a Phase II, Phase III or Phase IV clinical trial. Coverage may be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.
  - Clinical trials must be approved by one of the following:
    - NCI (National Cancer Institute);
    - An NCI cooperative group or NCI center;
  - The FDA (Federal Food and Drug Administration) in the form of an investigational new drug application;The Federal Department of Veterans Affairs; or
  - An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.
  - The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training and expertise.
  - Coverage shall be provided only if:
    - There is no clearly superior, non-investigational treatment alternative;
    - The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; and
    - The member and the physician or health care provider who provides services to the member under this paragraph conclude that the member's participation in the clinical trial would be appropriate.

Coverage does not include the cost of non-health care services, such as travel or lodging, costs associated with managing the research associated with the clinical trial or the cost of the investigational drug or device.

Limited Benefits

- Chiropractic services, when authorized and provided by the Plan's designated provider for this service listed in the directory of Providers. **You pay** a $10 copayment per visit and you are limited to 20 visits per member per calendar year.

- Oral and maxillofacial surgery: Benefits for the following functional repairs are provided when arranged by your primary care doctor and authorized by the plan:
  - nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate,
  - medically necessary medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses or related to temporomandibular joint (TMJ) pain dysfunction syndrome
  - All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered.

- Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

- Rehabilitative Services: When performed by a Plan provider and authorized by the Plan, short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to 90 days per condition if significant improvement can be expected within 90 days; **you pay** a $20 copay per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

- Diagnosis and treatment of infertility is covered; **you pay** $20 per outpatient visit. The following types of artificial insemination are covered according to accepted standards of medical practice and when authorized in advance by the Plan: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI); **you pay** a $20 copay per outpatient visit; the cost of donor sperm is not covered. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.

- Standard Durable Medical Equipment: Rental or purchase (as determined by the Plan) of standard durable medical equipment (including prosthetics, breast prostheses, surgical bras, and orthotics) is covered if authorized as medically necessary by the Plan. Durable medical equipment must be obtained from the designated Plan provider for this service. Durable medical equipment is limited to $1,000 per member per calendar year for any combination of items; **you pay** all charges thereafter.

- Early intervention services are covered up to $5,000 per member per calendar year for any combination of services. Early intervention services are the medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for covered dependents from birth to age three. The dependent must be certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act. Medically necessary early intervention services include those designed to help an individual attain or retain the capability to function age appropriately within his or her environment. It also includes services that enhance functional ability without effecting a cure.

- Podiatric services, limited to services for diabetic foot debridement.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel

- Services for, or related to, reversal of voluntary, surgically-induced sterility

- Services for, or related to, surgery primarily for cosmetic purposes

- Transplants not listed as covered

- Services for, or related to, routine vision and hearing care, except as provided herein, including hearing aids and refractive keratoplasty

- Corrective appliances, artificial aids, devices or equipment not specified herein, including penile implants

- Homemaker services

- Long-term rehabilitative therapy

- Eyeglasses and their fittings, and contact lenses

- Routine foot care

- Charges for missed appointments, phone calls, completion of insurance forms, copy or transfer of medical records, returned checks, or stop-payment on checks

Hospital/Extended Care Benefits

What is covered

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** a $100 copay per inpatient admission. All medically necessary services are covered, including:

Hospital care

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing
- Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits up to 100 days per illness or condition when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay** nothing. 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.

Hospice care

Hospice care as authorized by the Plan will be covered for members diagnosed with a terminal illness with a life expectancy of six months or less. Covered services include the following:

- skilled nursing care;
- home infusion therapy drugs for palliative care and pain management;
- services of a medical social worker;
- services of a home health aide or homemaker;
- physical, speech or occupational therapy;
- durable medical equipment;
- routine medical supplies;
- routine lab services;
- counseling, including nutritional counseling, with respect the Member's care and death;
- bereavement counseling for immediate family members both before and after the member's death; and
- short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the Member in order to provide the Member's primary caregiver a temporary break from caregiving responsibilities. Respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided for more than five days every 90 days.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited Benefits

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 19 for nonmedical Substance Abuse Benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care
- Inpatient dental procedures

Emergency Benefits

What is a medical emergency?

Emergency means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, or (ii) danger of serious impairment of the individual's body functions, or (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor or a nurse advisor at 1-800/382-9625. In extreme emergencies, if you are unable to contact your doctor or a nurse advisor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest appropriate medical facility.

If you need to be hospitalized, you or your representative must notify your primary care doctor within 48 hours or on the first working day following your admission, unless it was not reasonably possible to do so. 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.

Plan pays...

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay...

A $50 copay per hospital emergency room visit or a $20 copay per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, inpatient services are subject to the hospital admission copay of $100 and the emergency room visit copay is waived.

Emergencies outside the service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. If an emergency occurs when you are temporarily outside the service area, you should obtain care at the nearest medical facility. You or your representative is responsible for notifying your primary care doctor within 48 hours or on the next business day.

If you need to be hospitalized, you or your representative must notify your primary care doctor within 48 hours or on the first working day following your admission, unless it was not reasonably possible to do so. 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.

Plan pays...

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay...

A $50 copay per hospital emergency room visit or a $20 copay per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, inpatient services are subject to the hospital admission copay of $100 and the emergency room visit copay is waived.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors services
- Ambulance service approved by the Plan

What is not covered

- Elective care or nonemergency 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
- Charges incurred after your condition would permit you to travel to the nearest Plan facility

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 9.

Mental Conditions / Substance Abuse Benefits

Mental Conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; **you pay** a $20 copay for each covered visit-all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** a $100 copay per admission for the first 30 days-all charges thereafter.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition
- Treatment for mental retardation, mental deficiency and learning disabilities
- Treatment which is not authorized by the Plan doctor

Substance Abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

Up to 20 outpatient visits for Plan providers for treatment each calendar year; **you pay** a $20 copay for each covered visit, all changes thereafter.

The substance abuse benefit may be combined with the outpatient mental conditions benefit shown above, provided such treatment is necessary and is approved by the Plan, to permit an additional 20 outpatient visits per calendar year with the applicable mental conditions benefit copayments.

Inpatient care

Up to 30 days per calendar year in a substance abuse rehabilitation (intermediate care) program in an alcohol detoxification or rehabilitation center approved by the Plan; **you pay** a $100 per inpatient admission copay, subject to a lifetime maximum of 90 days-all charges thereafter.

What is not covered

- Treatment that is not authorized by the Plan provider.

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 31-day supply or a quantity of 100, whichever is less. **You pay** a $5 copay (first tier), a $10 copay (second tier), or a $25 copay (third tier).

All covered brand name and generic drugs are categorized into three specific tiers, and each tier is assigned a copayment level:

- First tier: Low cost prescription drugs, typically generic drugs
- Second tier: Moderate-cost prescription drugs, typically multi-source brand name drugs. A multi-source brand name drug is a brand name drug with a generic equivalent
- Third tier: High-cost prescription drugs, typically single source brand name drugs. A single source brand name drug is a brand name drug without a generic equivalent

You may request a brand name drug and pay the difference between the brand name drug and the generic drug, in addition to your appropriate copayment.

- Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Nonformulary drugs will be covered when prescribed by a Plan doctor. The Plan receives financial credits from drug manufacturers based on the total volume of claims processed for their products used by members. These credits are used to help stabilize premiums. Reimbursements to pharmacies are not affected by these credits.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Oral and injectable contraceptive drugs; contraceptive diaphragms; intrauterine devices and Norplant are covered under prescription drug or medical and surgical benefits
- For members with diabetes, insulin with a copay charge applied to each vial; insulin syringes, needles, blood glucose test strips, lancets and glucometers; coverage for glucometers is limited to one per member every 12 months
- Disposable needles and syringes needed to inject covered prescribed medication
- Intravenous fluids and medication for home use and some injectable drugs are covered under Medical and Surgical Benefits

Limited Benefits

Drugs to treat sexual dysfunction are subject to dosage limitations. Contact the Plan for the dosage limitations.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Diabetic supplies (except needles, syringes, blood glucose test strips, glucometers and lancets as specifically covered) including glucose test tablets and test tape, Benedict's solution or equivalent, and acetone test tablets
- Drugs for weight control
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Drugs to aid in smoking cessation, including nicotine patches
- Fertility drugs

Other Benefits

Dental care

Accidental injury benefits

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; **you pay** a $20 copay per specialist doctor visit. A treatment plan must be submitted within 60 days of the accidental injury and approved by the Plan.

What is not covered

- Accidental injury to teeth caused by biting or chewing related injuries
- Other dental services not shown as covered

Vision care

What is covered

In addition to the medical and surgical benefits provided for the diagnosis and treatment of diseases of the eye, members may receive one eye examination every contract year, including lens prescriptions, from designated Plan providers. **You pay** a $10 copay per visit. **You pay** an additional $25 copay for a contact lens examination from designated Plan providers.

What is not covered

- Corrective lenses or frames
- Eye exercises

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Trigon Individual Dental

For an additional premium, Trigon offers an individual dental program within its service area that covers both preventive and diagnostic services, and provides certain benefits for important restorative, orthodontic and prosthodontic services. Please call 1-888-7TRIGON for more information.

Expanded Vision Care

Trigon HealthKeepers offers a 25% discount on vision services and supplies when received from the Plan's vision care vendor. This program is available at no additional cost to you.

Trigon HealthKeepers Family Health Program

The Plan offers the Trigon HealthKeepers Family Health Program, which includes discounts at health clubs throughout Virginia, and other health programs such as the award-winning Baby Benefits prenatal care program, the 24-hour Nurse Advisor Line, the HealthLine Audiotape Library, the Trigon HealthNews Newsletter, and more. The Trigon HealthKeepers Family Health Program is available at no additional cost to you.

Baby Benefits Program

Trigon HealthKeepers offers Baby Benefits, a prenatal program for expectant parents designed to promote a healthy pregnancy. This program has been recognized for its success by winning the C. Everett Koop National Health Award. HealthKeepers enrollees will be automatically enrolled when their primary care doctor confirms pregnancy, and will receive information materials, access to a Baby Benefits nurse consultant, a prenatal book, and gifts for the parents and baby. This program is available to the enrollee at no additional cost.

Benefits on this page are not part of the FEHB contract

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 or condition.

We do not cover the following:

- Services, drug or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and 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;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

TRICARE

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

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 1-800/421-1880, or in the Richmond area at 358-7390, or write to:

HealthKeepers, Inc.
P.O. Box 26623
Richmond, Virginia
23285-0031

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

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

What happens when I 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, which is described later in this section.

What types of coverage are available for my family and me?

Self-Only coverage is for you alone. *Self and Family* coverage is for you, your spouse, and your unmarried dependent childrin under age 22, including andy foster or sepchildren your employing office of retirement office authorizes coverage for. Under certain circumstances, you mayt also get coverage for a disabled child 22 years of age or older who is incapable of self-support, which is also authorized by your employing or retirement office.

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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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. No new enrollment form is necessary.

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

Are my medical and claims records 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse 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 more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct. Get the RI 79-27, which describes TCC, and the RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees from your employing or retirement office.

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends;
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed;
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs;
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium;
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service, your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

How can I get a Certificate of Group Health Plan Coverage?

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

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

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 1-800/421-1880, or in the Richmond area at 358-7390 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Trigon HealthKeepers 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated, subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

	Benefits	Plan pays/provides	Page
Inpatient Care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in- hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** a $100 copay per admission	16
	Extended Care	All necessary services, up to 100 days per illness or condition. **You pay** nothing	16
	Hospice Care	All necessary services. **You pay** nothing	16
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** a $100 copay per admission for the first 30 days -all charges thereafter	18
	Substance Abuse	Up to 30 days in a substance abuse treatment center per year, limited to a lifetime maximum of 90 days. **You pay** a $100 per admission copay	19
Outpatient Care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay per primary care doctor office visit; $20 copay for an authorized specialty doctor office visit or a doctor house call. For Ambula tory/Outpatient Surgery, **you pay** a $20 copay for services received in a specialist's office, and a $50 copay for services received in a freestanding or hospital based center	11
	Home Health Care	All necessary visits by nurses and health aides. **You pay** nothing	13
	Chiropractic Care	Up to 20 outpatient visits per year. **You pay** a $10 copay per visit	14
	Mental Conditions	Up to 20 outpatient visits per year. **You pay** a $20 copay per visit	18
	Substance Abuse	Up to 20 outpatient visits per year. **You pay** a $20 copay per visit	19
Emergency Care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $50 copay per emergency room visit, or a $20 copay per visit to an urgent care center and any charges for services not covered by this Plan	17
Prescription Drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 copay (first tier), $10 copay (second tier), or $25 copay (third tier) per prescription unit or refill	19
Dental Care		Accidental injury benefit. **You pay** a $20 copay per doctor visit	20
Vision Care		One eye refraction per year. **You pay** a $10 copay per visit, and an additional $25 copay for contact lens exams	20
Out-of-pocket Maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,500 per member or $3,000 per family per calendar year, benefits will be provided at 100%. This copay maximum does not include prescription drugs, dental services, vision care, chiropractic services, or outpatient mental health and substance abuse care	7

2000 Rate Information for
Trigon HealthKeepers

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

Postal rates apply to most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	**X81**	**$66.14**	**$22.05**	**$143.31**	**$47.77**	**$78.27**	**$9.92**	**$78.27**	**$9.92**
Self and Family	**X82**	**$167.97**	**$55.99**	**$363.94**	**$121.31**	**$198.76**	**$25.20**	**$198.76**	**$25.20**