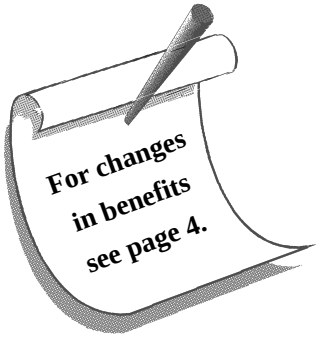
KEYSTONEBLUE
A Blue Cross and Blue Shield HMO
from Keystone Health Plan West

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

KEYSTONEBLUE 2000

A Health Maintenance Organization



Serving: The Pittsburgh, Altoona and Erie, Pennsylvania areas

Enrollment in this Plan is limited; see page 5 for requirements.

Enrollment code:

EF1 Self Only

EF2 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
This Plan's website at http://www.highmark.com

Authorized for Distribution by the:
United States Office of Personnel Management

FEHB
Federal Employees Health Benefits Program

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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 you can receive from 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 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 understandable 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 KeystoneBlue 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.

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 groups 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 KeystoneBlue's non-postal premium will increase by 38.5% for Self Only or 113.1% for Self and Family.
- If you or your dependents have a serious mental illnesses as defined by the American Psychiatric Association including schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, delusional disorder, you are now entitled to coverage for at least 30 days of inpatient care and 60 days of outpatient care annually. Inpatient days can be converted to outpatient days on a one-for-two basis.
- This brochure now states that coverage is provided for breast reconstruction following a mastectomy that includes reconstruction of the unaffected breast for symmetry. Previously, this was covered through interpretation of the reconstructive surgery benefit.
- Coverage is provided certain prescription drugs when related to diabetes. The following supplies, among others, are covered when related to the treatment of diabetes: injection aids, syringes, blood glucose monitors, test strips, and orthotics.

- Emergency care services are covered without prior approval or referral. Emergency service is defined as any health care service provided to a member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the member, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

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 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, Clearfield, Elk, Huntingdon, Indiana, Jefferson, 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. 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 you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Reciprocity

Away from Home Care: The Away from Home Care program "HMO Blue USA" is the Blue Cross and Blue Shield Association's basic reciprocity program. The HMO Blue USA program offers Plan members urgent care and guest membership at participating Blue Cross and Blue Shield HMOs throughout the United States. The participating HMO will bill the Plan for urgent care charges or guest membership services. You will be responsible for paying non-covered benefits. The Plan will pay all other charges at 100% for outpatient treatment and inpatient admissions minus any applicable copayments or deductibles. A toll free number (1-800-4HMO-USA) is available for contacting a participating HMO when you are outside the Plan Service Area and need urgent care treatment.

Your "Away From Home Care" 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 the "Away From Home Care" 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 PCP, 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.

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 a referred specialist's office visit. Your out-of-pocket expenses for benefits under this Plan are limited to the copayments stated in this brochure.

Do I have to submit claims?

No. We do not require you to submit claim forms.

Who provides my health care?

KeystoneBlue is an Individual Practice Prepayment (IPP) model HMO, offering you a choice of more than 1,500 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, Internal Medicine, or Pediatrics. In fact, we require our doctors to be specialty board certified.

Role of a primary care doctor

The first and most important decision you and your family members must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is your primary care doctor's responsibility to obtain any necessary authorizations from us before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a referral by the appropriate primary care doctor, with the following exception: a woman may see her Plan obstetrician/gynecologist without a referral. A woman may self refer to any KeystoneBlue network OB/GYN directly for any gynecological services without a referral from her primary care doctor and may receive medically necessary and appropriate follow-up care and referrals for diagnostic testing without prior approval of PCP. The OB/GYN will manage the care of the member for any gynecological services and establish the treatment plan for the member. All female members are encouraged to receive an annual routine exam including a pelvic exam and clinical breast exam and one Papanicolaous (PAP) smear per calendar year.

Choosing your doctor

Our provider directory lists primary care doctors (generally family practitioners, pediatricians, and internists) with their locations and phone numbers and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Service Department at 1-800-421-0959; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

If you enroll, we will ask you to complete a primary care doctor selection form and send it directly to us. You will need to indicate the name of the primary care doctor(s), and the doctor's number (as indicated in the directory), that you have selected for you and each member of your family. You may change all doctor selections by notifying our Member Service Department. If you contact Member Service before the 15th of the month, the change will be effective the first day of the following month. If you contact Member Service after the 15th of the month, the change will be effective the first day of the second following month.

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

We will notify you of the doctor's departure from our network and ask you to select a new primary care doctor.

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 1-800-421-0959. 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. Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, you must receive a referral from your primary care doctor or Blues On Call℠ before seeing any other doctor or obtaining special services. Blues On Call is a toll-free, 24-hour health care advice and assistance number (1-888-BLUE-428) that connects you to a specially-trained registered nurse who provides care assistance, including referrals to network specialists when appropriate. Referrals to a participating specialist are given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals.

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. You may also be entitled to receive a 60 day standing referral to your specialist if certain criteria are met. Your PCP can coordinate this for you.

When you receive a referral from your primary care doctor or Blues On Call, you may be treated by the consultant doctor up to 60 days from the time of issuance of the referral. All diagnostic testing and follow-up care can be provided or arranged by the consulting doctor. If additional services or visits are suggested by the consultant beyond the 60 day limit, you must first check with your primary care doctor and obtain an additional referral. Do not go to the specialist unless your primary care doctor or Blues On Call has arranged for and the Plan has issued an authorization for the referral in advance.

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. However, you may be able to continue care with a non-Plan provider for up to 60 days after your effective date of coverage on this Plan. Coverage may be extended beyond 60 days if clinically appropriate.

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?

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.

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 verbal or 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 1-800-547-9378 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 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

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $10 copay for a primary doctor's office visit; nothing for a referral specialist's office visit, but no additional copay for laboratory tests and X-rays. 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 $10 copay for a doctor's house call; nothing for home visits by nurses and health aides.

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

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: an initial baseline mammographic screening for all female Members between 35 and 40 years of age; for women age 40 and over, one annual mammogram screening every year. In addition to routine screening, mammograms are covered regardless of age when prescribed by the primary care doctor or network OB/GYN as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. Copays are waived for maternity care. 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.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum); copay is waived
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints; breast prosthesis and surgical bras, as well as their replacement.
- Cornea, heart, heart/lung, kidney, liver, lung (single or double), pancreas/kidney, skin and tissue transplants; allogeneic (donor) bone marrow transplants; 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 when approved by the Plan medical director. Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan. All transplant services must be pre-determined in writing by the plan.
- 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 at a participating facility or in the home when authorized by the plan.
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Orthopedic devices, such as braces; custom molded foot orthotics (requires prior authorization by the Plan)
- Standard durable medical equipment, such as wheelchairs and hospital beds (requires prior authorization by the Plan)

What is covered
continued

- Prosthetic devices, such as artificial limbs and lenses following cataract removal (requires prior authorization by the Plan)
- Home health services of nurses and health aides, when prescribed 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

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures, excision of tumors and cysts, and extractions of impacted third molars when partially or totally covered by bone. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

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.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to 60 days per condition if significant improvement can be expected within 60 days; **you pay** nothing 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.

A patient and her attending physician may decide whether to have **breast reconstruction surgery** following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Diagnosis and treatment of infertility is covered; **you pay** up to $200 or 50% of the cost of the plan of treatment, whichever is less. The following types of **artificial insemination** are covered: intravaginal insemination (IVI), intracervical insemination (ICI) and intrauterine insemination (IUI); **you pay** up to $200 or 50% of the cost of the plan of treatment, whichever is less; cost of donor sperm is not covered. Fertility drugs are covered with prior authorization from the plan. **Other assisted reproductive technology** (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is covered in full at a Plan facility for up to 12 weeks; **you pay** nothing. All services must be authorized by your primary care doctor and KeystoneBlue.

Chiropractic services are covered, but coverage is limited to spinal manipulations.

Enteral Formulae is covered when administered on an Outpatient basis, either orally or through a feeding tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria, and, when medically necessary and appropriate for the member's medical condition when Enteral Formulae is the sole source of nutrition and utilized instead of regular shelf food or regular infant formulae. Benefits for Enteral Formulae are exempt from any applicable deductible requirements, but policy limitations and maximums do apply.

In order to receive Enteral Formulae, the member must receive prior authorization from the Plan by meeting specific medical criteria. Coverage for Enteral Formulae will continue as long as the Formulae represent at least 50% of the member's daily caloric requirements. Enteral Formulae coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders or when utilized for the sole purpose of weight loss or gain. The coverage does not cover blenderized food, baby food or infant formulae with intact proteins.

Medical and Surgical Benefits *(continued)*

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
- Storage of blood, except when done in preparation for a scheduled surgical procedure.
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Hearing aids
- Transplants not listed as covered
- Long-term rehabilitative therapy
- Homemaker services
- Services related to contraceptive devices including diaphragms and implanted contraceptive medications such as Norplant.
- Immunizations required for foreign travel
- Hair growth stimulants and hair replacement
- Weight reduction programs
- Charges for missed appointments
- Radial keratotomy

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no day limit when you are hospitalized under the care of a Plan doctor. **You pay** a $100 copay per admission; if readmitted within 60 days of the first admission, regardless of condition, no additional copay is due. Once inpatient hospital admission copayments incurred total $300 per individual or $500 per family in a calendar year, no further inpatient copayment is required of that individual or family in that calendar year.
All necessary services are covered, including:

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

Extended care

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. **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

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.

Ambulance service

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

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

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 16 for nonmedical Substance Abuse Benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Blood and blood derivatives not replaced by the member
- Custodial care, rest cures, domiciliary or convalescent care
- Private duty nursing when provided in an inpatient setting

Emergency Benefits

What is a medical emergency

Emergency care services are covered without prior authorization or referral. Emergency service is defined as any health care service provided to a member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the member, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Emergencies within the 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 with 48 hours of the emergency care or as soon as reasonably possible to facilitate a follow-up call.

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.

Plan pays...

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

You pay...

$50 per emergency room visit or urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care 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 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.

Plan pays...

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

You pay...

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

The HMO Blue USA program offers Plan members urgent care and guest membership at participating Blue Cross and Blue Shield HMOs throughout the United States. The participating HMO will bill this Plan for urgent care charges or guest membership services. You will be responsible for paying non-covered benefits. The Plan will pay all other charges at 100% for outpatient treatment and inpatient admissions minus any applicable copayments or deductibles. A toll free number (1-800-4HMO-USA) is available for contacting a participating HMO when you are outside the Plan Service Area and need urgent care treatment.

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 if 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 departing the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area

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

You may self-refer to this Plan's mental health administrator for treatment of mental conditions and substance abuse. The mental health administrator will make all subsequent determinations of appropriate treatment and which specialists will be used. Call us for the name and phone number of our mental health administrator.

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 $25 copay for each covered visit — all charges thereafter.

Up to 60 days of outpatient care for serious mental illness per calendar year; **you pay** a $25 copay for each covered visit — all charges thereafter. Serious mental illness is defined by the American Psychiatric Association to include schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, and delusional disorder.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** nothing for first 30 days — all charges thereafter. For serious mental illness, as defined above, you are covered for at least 30 days of inpatient care; same inpatient care copay applies. Inpatient days can be converted to outpatient days on a one-for-two basis.

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

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.

Inpatient detoxification care

Up to seven (7) days per admission with a lifetime maximum of four admissions in a facility approved by the Plan.

Inpatient rehabilitation care

Up to 30 days substance abuse rehabilitation program per calendar year with a lifetime maximum of 120 days in a Rehabilitation Center approved by the Plan; **you pay** nothing during the benefit period — all charges thereafter.

Outpatient care

Up to 60 outpatient visits per calendar year and 120 visits per lifetime to Plan providers for treatment; **you pay** nothing for the first course of treatment, second and additional courses of treatment will be subject to a $25 copay per visit or 50% of allowable charges whichever is less — all charges thereafter.

What is not covered

- Treatment that is not authorized by a Plan doctor

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 maximum 34-day supply. Generic drugs may be dispensed when substitution is permissible; **you pay** an $8 copayment per prescription or refill. When generic drugs are available and the prescribing doctor requires the use of a name brand drug, **you pay** a $14 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 pay** a $14 copayment per prescription or refill plus the price difference between the generic and name brand drug.

MAIL ORDER: A mail order program is available to provide up to a 90-day supply of maintenance drugs. **You pay** a single copay for each 90-day supply.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- All FDA approved contraceptive drugs and devices. Up to a three-cycle supply of oral and injectable contraceptive drugs may be obtained for a single copay 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
- Implanted time-release medications (provided at no charge)
- Prenatal vitamins
- Fluoride vitamins
- Fertility drugs (requires prior authorization by the Plan)
- Intravenous fluids and medications for home use (provided under home health services at no charge) and some covered injectable drugs are covered under Medical and Surgical Benefits

What is not covered

- Drugs available without a prescription or for which there is a non-prescription 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
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Drugs or other devices to aid in smoking cessation
- Weight loss drugs

Other Benefits

Dental care

Accidental injury benefit

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** nothing.

What is not covered

• Treatment for accidental dental injury caused by chewing

Vision

OptiChoice™ is our Preferred Provider 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. 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.

What is covered

Benefit	You pay
Eye Examination and Refractive Service	Nothing
Contact Lens Prescription and Fitting	Nothing
Post Refractive Services	
Frames	All charges in excess of $60
Single Vision Lenses (Standard)	Nothing
Bifocal Vision Lenses (Standard)	Nothing
Trifocal Vision Lenses (Standard)	Nothing
Aphakic Vision Lenses (Standard)	Nothing
Single Vision Lenses (Non-standard)	90% of the difference betweeen the normal charge and the non-standard charge for the same type of Standard lenses.
Bifocal Vision Lenses (Non-standard)	
Trifocal Vision Lenses (Non-standard)	
Aphakic/Lenticular Vision Lenses (Non-standard)	
Hard Contact Lenses (Standard)	Nothing
Soft Contact Lenses (Standard)	Nothing
Specialty Contact Lenses (Standard)	All charges in excess of $75
Vision Care Options (tints, contact lens solutions, etc.)	The cost of the items less a 10% discount
Additional Post-Refractive Services	All charges in excess of the Program's Allowance

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 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.

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

All KeystoneBlue members have access to "Blues On Call." Blues On Call is a toll-free, 24-hour health care advice and assistance number that connects you to a specially-trained registered nurse who provides care assistance, including referrals to network specialist when appropriate. You can use Blues On Call 24-hours-a-day … to speak confidentially with a registered nurse about everyday health concerns or major health decisions … listen to up-to-date recorded information on more than 430 health care topics … and get help locating health care resources, such as support groups and community services.

• Medicare prepaid plan enrollment

This plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 20, annuitants and former spouses with coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those **without** Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on changing your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-576-6343 for information on Plan benefits under the Medicare plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 800-576-6343 for information on the benefits available under the Medicare HMO.

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, drugs 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.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages, you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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 1-800-547-9378, or write to Keystone Health Plan West, Inc., Claims, P.O. Box 898819, Camp Hill, PA 17089-8819. Or visit our website at www.highmark.com.

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 children under age 22, including any foster or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may 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,
- 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 1-800-421-0959 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.

Notes

Summary of Benefits for KeystoneBlue — 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 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** $100 per admission	**12**
	Extended care	All necessary services, for up to 100 days per year. **You pay** nothing	**12**
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** nothing	**16**
	Substance abuse	For treatment of substance abuse other than alcoholism, one 30 day program per year; for alcoholism, one 30 day program per year; benefits subject to lifetime maximum; **You pay** nothing	**16**
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 visit for an office visit or house call by a primary care doctor; nothing for referral care to specialists	**10**
	Home health Care	All necessary visits by nurses and health aides. **You pay** nothing	**11**
	Mental conditions	Up to 20 outpatient visits per year. **You pay** a $25 copay per visit	**16**
	Substance abuse	For treatment of substance abuse other than alcohol, up to 30 outpatient visits per year (120 visits per lifetime maximum); **you pay** nothing. For alcoholism, up to 60 outpatient visits per year; **you pay** nothing for the first course of treatment, $25 copay per visit or 50% of charges (whichever is less) for additional courses up to visit limit	**16**
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** $50 per visit for emergency room visits, waived if you are admitted, and any charges for services that are not covered by this Plan	**14**
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** an $8 copay per prescription unit or refill for generic drugs. When generic drugs are available and the prescribing doctor requires the use of a name brand drug, **you pay** the $14 copayment per prescription or refill. If you request a name brand drug, **you pay** a $14 copay per prescription unit or refill plus the difference in cost between the generic and name brand drug. A mail order service is available for maintenance medication; **you pay** a single copay for each 90 day supply	**17**
Dental care		Accidental injury benefit, **you pay** nothing.	**18**
Vision care		Paid-in-full benefits are available on standard services through the OptiChoice™ In-Network Annual Benefits Program.	**18**
Out-of-pocket limit		Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments required for a few benefits	**5**

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United States Office of Personnel Management

Federal Employees Health Benefits Program

2000 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 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	**EF1**	**$ 72.29**	**$24.09**	**$156.62**	**$ 52.20**	**$ 85.54**	**$10.84**	**$ 85.54**	**$10.84**
Self and Family	**EF2**	**$175.97**	**$109.96**	**$381.27**	**$238.25**	**$207.74**	**$78.19**	**$201.02**	**$84.91**