HealthAmerica Pennsylvania, Inc.

http://www.healthamerica.cvty.com

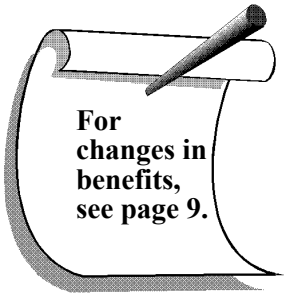
2012

(Central Pennsylvania)

A Health Maintenance Organization

Serving: *Central Pennsylvania*

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.



Enrollment codes for this Plan:
Central Area
SW4 Standard Option Self Only
SW5 Standard Option Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from HealthAmerica About

Our Prescription Drug Coverage and Medicare

OPM has determined that the HealthAmerica's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and we'll coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's as least as good as Medicare's prescription drug coverage, your monthly premium will go up a least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY (1-877-486-2048).

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Introduction

This brochure describes the benefits of under our contract (CS 2078) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for administrative offices is:

HealthAmerica Pennsylvania, Inc

3721 TecPort Drive PO Box 67103

Harrisburg, PA 17111

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and System Support, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.

- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider 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 866-351-5946 and explain the situation.
    - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 (unless he/she was disabled and incapable of self -support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1.Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.

- Take a relative or friend with you to help you ask questions and understand answers.

2.Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3.Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4.Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5.Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take? "
  - "What will happen after surgery"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will no longer be billed for inpatient services that HealthAmerica determines as "Never Events." When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We are adopting a benefit payment policy that will encourage hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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

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

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

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

As a non-grandfathered health plan (or option), this plan (or option) has also decided to follow the requirements that apply to grandfathered plans.

Questions regarding what protections apply and what protections do not apply to a grandfathered health plan, and what might cause a plan to change status from grandfathered to non-grandfathered may be directed to us at ***1-866-351-5946.*** You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General Features of our Standard Option

If you enroll in the Standard Option coverage, you must satisfy an annual deductible of $750 per Self Only enrollment or $1,500 per Self and Family enrollment. After you have satisfied the Standard Option annual deductible, you simply pay 15% coinsurance for covered surgical procedures and inpatient hospitalization up to the out-of-pocket maximum of $4,750 under Self Only and $9,500 (including deductible) under Self and Family. We will apply the annual deductible to your annual out-of-pocket limit.

The Standard Option coverage affords you protection from catastrophic illness because there is a limit to your out-of-pocket costs for covered care. After you have met the out-of-pocket maximum under the Standard Option coverage, we eliminate the coinsurance that you are required to pay for most covered procedures. Please note that you must still make copayments for covered office visits and prescription drugs.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Our providers are paid on a capitated basis or a fee for service basis according to negotiated contracts. We do not participate in any withholds/bonus or incentive programs.

Your Rights

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

- We are compliant with Federal and state licensing requirements. We have been a licensed HMO since 1975.
- We have been in existence for over 36 years.

- We are a for-profit HMO.
- We have participated with the FEHB program since 1977.

If you want more information about us, call (866) 351-5946 or write to HealthAmerica Pennsylvania, Inc. 3721 TecPort Drive, PO Box 67103, Harrisburg, PA 17111. You may also contact us by visiting our Web site at www.healthamerica.cvty.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live or work in our Service Area. This is where our providers practice.

Enrollment code SW (Central area) includes the following Pennsylvania counties: Adams, Berks, Blair, Bradford, Centre, Clearfield, Clinton, Columbia, Cumberland, Dauphin, Franklin, Huntingdon, Juniata, Lancaster, Lebanon, Lehigh, Lycoming, Mifflin, Montour, Northampton, Northumberland, Perry, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union and 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 benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member moves outside of our service area, you can enroll in another plan. If your dependents live out of the area, you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you have a dependent student who is a full-time student, temporarily attending school out of state, we do offer limited coverage through this plan. See page 50. If you or a family member moves, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we changed for 2012

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

Program wide changes:

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to the Standard Option:

- No benefit changes
- For postal premium rates, please refer to the applicable category on the rate page.
- Your share of the non-postal premium will increase for Self Only and increase for Self and Family.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (866) 351-5946 or you may request replacement cards through our Web site at www.healthamerica.cvty.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance.

- **Plan providers**

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

We list Plan providers on our Web site at www.healthamerica.cvty.com or you can call the Plan.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list providers on our Web site at www.healthamerica.cvty.com.

What you must do to get covered care

It depends on the type of care you need. First you and each family members must choose a primary care physician (PCP). This decision is important since your primary care physician provides or arranges for most of your health care. You can complete a PCP Selection card and mail it or you can call us.

- **Primary care**

Your Primary Care Physician can be a family practitioner, internist or a pediatrician. Your Primary Care Physician will provide most of your health care, or coordinate your care to see a specialist. If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Our plan does not require you to obtain referrals to see specialists, however the provider must be in our network. If you go to a non-participating provider, benefits will be denied, except for Emergency services and Urgent Care Services outside of the Service Area and certain referrals as provided below.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your physician will work with us to develop a treatment plan that allows you to continue seeing your specialist. Your physician will use our criteria when creating your treatment plan. The participating network provider may have to get our prior approval for certain services.
- The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

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

- terminate our contract with your specialist for other than cause;
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
- reduce our service area and you enroll in another FEHB Plan;

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

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

- **Hospital care**

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

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins call our customer service department immediately at 866-351-5946. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

- you are discharged, not merely moved to alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitilized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Services requiring our prior approval**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. The following are health care services which require pre-certification:

- Inpatient hospital admissions
- Extended Care/Skilled Nursing Facility
- Outpatient surgeries
- Bariatric surgery for morbid obesity
- Home health care
- Durable medical equipment

- Out of network referral requests
- Transplant requests
- Complex diagnostic testing such as Magnetic Resonance Imaging
- Infertility treatment
- Growth Hormone Therapy (GHT)
- Mental Health and Substance Abuse treatment *
- Pain management programs
- Genetic Testing
- Hospice Care
- Cardiac Rehabilitation

* You must contact MHNet Behavioral Health before seeking mental health and substance abuse treatment. MHNet Behavioral Health will help develop a treatment plan that you must follow. We will not cover services that MHNet Behavioral Health has not approved.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 866-351-5946 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayments	A co-payment (or copay) is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. **Standard Option** example: when you see your primary care physician you pay a co-payment of $25 per office visit—and when you visit a specialist the co-payment is $50.
Cost-sharing	Cost-sharing is a general term used to refer to your out-of -pocket costs (e.g. deductibles, coinsurance, and copayments) for the covered care you receive.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them under the Standard Option coverage. Copayments under the Standard Option coverage do not count toward the deductible. **Standard Option**: The calendar year deductible for the Standard option is $750 per person under Self Only enrollment and $1,500 per Self and Family enrollment. Under family coverage, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $1,500. Note: If you change plans during open season, you must start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for covered care. Under the Standard Option Coverage, coinsurance doesn't begin until you have satisfied your deductible. **Standard Option** example: Under the Standard Option, you pay 15% after you have satisfied your deductible for covered inpatient hospitalization.
Your catastrophic protection out-of-pocket maximum	**Standard Option**: After the coinsurance that you pay for covered services totals $4,750 per person or $9,500 (including deductible) per family in a calendar year, you do not have to pay any more for covered services. Your annual out-of- pocket maximum will include deductibles. Your annual out-of-pocket maximum does not include copayments for office visits (or other covered care) and prescription drugs. It also does not include amounts that you pay for non-covered services. Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.
Carryover	If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Standard Option Benefits

See page 8 for how our benefits changed this year. Page 74 is a benefits summary of the standard option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. Standard Option Benefits Overview

This Plan offers a Standard Option. The benefit package is described in Section 5. Make sure that you review the benefits that are available under the option in which you enrolled.

The Standard Option Section 5 is divided into subsections. Please read the *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about Standard Option benefits, contact us at (866) 351-5946 or at our Web site at www.healthamerica.cvty.com.

Each option offers the following unique features:

Standard Option

- Annual deductible of $750 Self Only and $1,500 Self and Family (applies to most services except office visits and prescription drugs)
- Annual out-of-pocket expenses are limited to $4,750 per person or $9,500 per Self and Family enrollment
- No office visit copay for preventive care
- $25 per primary care office visit and $50 per visit to a specialist
- $125 copay per visit for accidental injury or medical emergency room treatment at a hospital.
- High-end Radiology services have a $125 copay. Those services include:
  - CAT Scans
  - MRI Scans
  - Magnetic Resonance Angiogram (MRA)
  - PET Scans
  - Computed Tomograpgy (CT) / Computed Tomography Angiogram (CTA)
  - Nuclear Stress (MPI)
  - Stress Echocardiogram
  - Diagnostic Nuclear Medicine
  - Multiple Gated Acquisition (MUGA)
  - Nuclear Cardiac Imaging / Myocardial Infusion Studies
- 15% coinsurance for each X-ray or Ultrasound after the annual deductible
- 15% coinsurance for covered inpatient hospital care after the annual deductible
- 15% coinsurance for the physician's charges for covered surgery after the annual deductible
- Nothing for lab tests such as urinanaysis and pap tests

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Under the Standard Option coverage, coinsurance applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- We have a deductible under the Standard Option. The calendar year deductible the Standard Option is $750 per person ($1,500 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. Copayments for office visits do not count toward the calendar year deductible or out-of-pocket maximum.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	$25 per office visit to your primary care physician $50 per office visit to a specialist (No deductible)
Professional services of physician • In an urgent care center • In a skilled nursing facilty	Nothing
At home	$25 per office visit to your primary care physician $50 per office visit to a specialist (No deductible)
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • Non-routine mammograms	Nothing (No deductible)
• Prenatal ultrasound	15% coinsurance

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay After the calendar year deductible
Lab, X-ray and other diagnostic tests (cont.)	
• X-rays • Ultrasound • Electrocardiogram and EEG	15% coinsurance
High-end Radiology	
• CAT Scans • MRI Scans • Magnetic Resonance Angiogram (MRA) • PET Scans • Computed Tomography (CT) / Computed Tomography Angiogram (CTA) • Nuclear Stress (MPI) • Stress Echocardiogram • Diagnostic Nuclear Medicine • Multiple Gated Acquisition (MUGA) • Nuclear Cardiac Imaging / Myocardial Infusion Studies	$125 copay (No deductible)
Preventive care, adult	
Routine physical examination	Nothing (No deductible)
Routine screenings, such as: • Total Blood Cholesterol - once every 3 years • Colorectal Cancer Screening, including - Fecal occult blood test - Double contrast barium enema - Colonoscopy screening	Nothing per office visit to your primary care physician Nothing per office visit to a specialist (No deductible)
Sigmoidoscopy, screening – every five years starting at age 50	Nothing (No deductible)
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing (No deductible)
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see *Diagnostic and treatment services* above.	Nothing (No deductible)
Routine mammogram • From age 35 through 39, one during this five year period • One per calendar year age 40 and above	Nothing (No deductible)
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	Nothing per office visit to your primary care physician

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible
Preventive care, adult (cont.)	
• Tetnus-diphtheria (Td) booster - once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccines, annually, age 50 and over at physician's decretion for those determined to be high risk • Pneumococcal vaccine, age 65 and over	Nothing per office visit to your primary care physician Nothing per office visit to a specialist (No deductible)
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing per office visit to your primary care physician Nothing per office visit to a specialist (No deductible)
• Well-child care charges for routine examinations, immunizations and care (up to age 22). • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations	Nothing per office visit to your primary care physician Nothing per office visit to a specialist (No deductible)
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary (you do not need to pre-certify the normal length of stay). We will extend your inpatient stay for you or you baby if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Sugical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$25 per office visit to your primary care physician $50 per office visit to a specialist Note: You pay the office visit copay for your first visit only. We waive the office visit copay thereafter for normal routine maternity care visit. 15% coinsurance after deductible for prenatal ultrasound and delivery

Benefit Description	You pay After the calendar year deductible
Family planning	
A range of voluntary family planning services, limited to: • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragm fitting Note: We cover oral and injectable contraceptives and diaphragms under the prescription drug benefit.	$25 per office visit to your primary care physician $50 per office visit to a specialist (No deductible)
• Voluntary sterilization Note: See Surgical procedures Section 5(b)	$50 per vasectomy $100 per tubal ligation (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	$300 copay per member or 50% of the cost of the service, whichever is less (No deductible)
Not covered: • *Fertility drugs* • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer(ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*

Benefit Description	You pay After the calendar year deductible
Allergy care	
• Testing and treatment	$25 per office visit to your primary care physician $50 per office visit to a specialist (No deductible)
• Allergy serum • Allergy injections	Nothing (No deductible)
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 30. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 11.	$25 per office visit to your primary care physician $50 per office visit to a specialist Note: You will owe 15% coinsurance after you have satisfied the annual deductible for all outpatient facility services.
Physical and occupational therapies	
Up to two consecutive months per condition per year for the services of each of the following: • qualified physical therapists • occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury and if significant improvement can be expected within two consecutive months. • Cardiac rehabilitation is limited to treatment for therapy conditions that in the judgment of a participating physician and the Medical Director are subject to significant improvement through short-term therapy. We will only cover one course of cardiac rehabilitation per episode.	$25 per office visit to your Primary Care Physician $50 per office visit to a Specialist Nothing per visit if services are provided by a participating Physical Therapist Nothing per visit during covered inpatient admission. (No deductible)
Not covered: (continued on next page)	*All charges*

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible
Physical and occupational therapies (cont.)	
• *Long-term rehabilitative therapy or rehabilitative therapy beyond two consecutive months per condition* • *Exercise programs*	*All charges*
Speech therapy	
Up to two consecutive months per condition for the services provided by a qualified speech therapist	$25 per office visit to Primary Care Physician $50 per office visit to a Specialist Nothing per visit if services are provided by a participating Speech Therapist Nothing per visit during covered inpatient admission.
Hearing services (testing, treatment, and supplies)	
• Hearing testing (one per contract year)	$25 per office visit to your Primary Care Physician $50 per office visit to a Specialist (No deductible)
• Hearing Aids (one pair every 36 months)	15% coinsurance
Not covered: • *All other hearing testing ; any additional charges to adjust the hearing aids that are not included in the purchase price of the hearing aid; hearing aid dispensing fees; any charges for warranties, batteries or routine maintenance; costs for upgrades to the equipment beyond the cost of the basic medically necessary hearing aid.*	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Nothing
• Under the Standard Option, we cover annual eye refractions for children only up to the age of 18. We do not cover eye refractions for anyone over the age of 18. Note: See Non-FEHB Program benefits for additional vision services. See page 51. Note: To find an Eye Med provider near you, visit our website at www.healthamerica.cvty.com or call member services at 1-866-351-5946.	$15 per office visit (No deductible)
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*

Benefit Description	You pay After the calendar year deductible
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See the "*Not covered*" section under orthopedic and prosthetic devices for information on podiatric shoe inserts.	$25 per office visit to your Primary Care Physician $50 per office visit to a Specialist (No deductible)
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, limbs, pacemakers, and surgically implanted breast implant following mastectomy, when authorized in accordance with the Plan's policies and procedures. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome when rheumatoid arthritis, ankylosing spondylitis, or disseminated lupus erythmatosus. • For hearing aids, see hearing services on page 24. Note: You must receive our preauthorization. Call us at (866) 351-5946 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	$125 copay per device (No deductible)
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics (except for diabetics)* • *Heel pads and heel cups* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Cochlear implant devices* • *Replacement due to neglect* • *Any dental care involved with the treatment of tempormandibular joint (TMJ) pain dysfunction syndrome or joint disorders* • *Dental prosthesis* • *Lumbar supports* • *Wigs*	*All charges*

Benefit Description	You pay After the calendar year deductible
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers Note: You must receive our preauthorization. Call us at (866) 351-5946 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	$125 copay per device (No deductible)
• Diabetes equipment such as blood glucose monitors, insulin infusion devices, and orthotic (for diabetics only)	Nothing (No deductible)
Not covered: • *Disposable items such as incontinent pads, catheters, irrigation kits, electrodes, ace bandages, elastic stockings, and dressings* • *Equipment which serves for comfort or convenience functions or is primarily for the convenience of a person caring for a member* • *Air conditioners* • *Corrective appliances that do not require prescription specifications or are used primarily for recreational sports* • *Humidifiers* • *Electric air cleaners* • *Exercise or fitness equipment* • *Elevators* • *Hot tubs* • *Hoyer lifts* • *Shower/bath bench* • *Routine servicing, e.g., testing, cleaning, regulating and checking of equipment* • *Special clothing of any type* • *Hearing devices of any type* • *Replacement due to neglect*	*All charges*

Benefit Description	You pay After the calendar year deductible
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	15% coinsurance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Homemaker services* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Services or supplies furnished by a person who is the spouse or relative of member or by non home health provider*	*All charges*
Medical Foods	
• Services for nutritional formulas as medically necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a Participating Provider • Elemental Formula: Prior authorization is required. Covered services according to Plan guidelines for formulas made up of single amino acids and simple sugars and if the following requirements are met. - You must require nutritional therapy to sustain life (that is, to meet 505 of your daily nutritional requirements); and - Adequate nutrition must not be possible with dietary adjustment and/ or oral supplements. Note: We will only cover medical foods when we authorize the services. Your Physician must see you within thirty (30) days before to begin the Prior Authorization process and any subsequent re-Authorization.	Nothing (No deductible)
Not covered: • *Food or food supplements, vitamins or other nutritional and over-the-counter electrolyte supplements except as specified above* • *Services that we have not authorized*	*All charges*
Chiropractic	
Up to 15 visits per calendar year for : • Manipulation of the spine and extremities or • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$50 per office visit (No deductible)
Not covered: • *Visits that exceed 15 per calendar year*	*All charges*

Benefit Description	You pay After the calendar year deductible
Alternative treatments	
Biofeedback when approved in conjunction with an approved pain management program or for the treatment of urinary and or fecal incontinence.	15% coinsurance
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Acupuncture* • *Biofeedback services not shown as covered*	*All charges*
Educational classes and programs	
Outpatient diabetes self-management training and education (including nutritional therapy) for persons with diabetes, when prescribed by a Plan Physician. Coverage includes: • visits that are medically necessary upon the diagnosis of diabetes; • visits where a Plan physician identifies and diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management; and • visits where a licensed physician identifies that a new medication or therapeutic process relating to the person's treatment or diabetes management is medically necessary.	$25 per office visit to your Primary Care Physician $50 per office visit to a Specialist (No deductible)
• Tobacco cessation program, which includes individual/group telephonic counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for up to four counseling sessions for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence. (No deductible)
• Childhood Obesity Education	Reference Section 5 - Non-FEHB Benefits Available to Plan Members for additional information on how to obtain childhood obesity educational materials.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have a deductible under the Standard Option. The calendar year deductible the Standard Option is $750 per person ($1,500 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. Copayments for office visits do not count toward the calendar year deductible or out-of-pocket maximum.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the pre-certification information shown in Section 3 to be sure which services require pre-certification and identify which surgeries require pre-certification.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns • Circumcision of newborn males Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	15% coinsurance
Voluntary sterilization (such as tubal ligation and vasectomy)	$50 copay for vasectomy or $100 copay for Tubal Ligation (No deductible)

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
• Surgical treatment of morbid obesity (bariatric surgery) Note: We cover medically necessary bariatric surgery if you are age 18 or over. We limit the covered bariatric surgery procedures to laparoscopic surgery or gastroplasty (gastric stapling) or roux-en-y gastric bypass (Roux-en-Y). Your physician must obtain preauthorization of the surgery. We will cover the surgery in our preferred network of Bariatric Centers of Excellence. We will not cover care outside our Bariatric Centers of Excellence unless we specifically authorize it. Please contact us for our complete medical policy. You must satisfy all of the following criteria. • Body mass index (BMI) more than 40 or BMI greater than 35 with documented co morbid conditions such as cardiopulmonary problems (e.g., severe apnea), Pickwickian Syndrome, obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis. • Morbid obesity has persisted more than 3 years and there is no treatable metabolic cause for obesity. • Failure to lose weight or has regained weight after participation in a 3 month physician supervised program within the past six months that included dietary therapy, physical activity and behavior therapy and support. • Completion of a psychological evaluation and surgical clearance by a cardiologist and pulmonologist. • Commitment to participate in a multidisciplinary program that will provide guidance on diet, physical activity, and social support.	15% coinsurance
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Cosmetic procedures*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymph edemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	15% coinsurance
Not covered:	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	
• *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate; • Excisions of lesions of the madible, mouth, lip, or tongue • Incision of accessory sinuses, mouth, salivary glands, or duct; • Manipulation of dislocations of the jaw; • Reconstruction or repair of the mouth or lis necessary to correct functional impairment caused by congenital condition and birth abnormalities; • Treatment of tumors; • Extraction of impacted third molars when partically or totally covered by bone; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	15% coinsurance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Orthodontia* • *Treatment of TMJ if dental related* • *Orthognathic or prognatic surgery when it is performed only to improve the appearance of a functioning structure*	*All charges*
Organ/tissue transplants	
These solid organ transplants are subject to medical necessity and experimental / investigational review by the Plan. Refer to Other Services in Section 3 for prior authorization procedures. Transplant services must be performed at a participating Center of Excellence. We approve and designate where all transplants must be performed including hospitals for specific transplant procedures. If you would like to know about a specific facility, please contact Customer Service. We cover related medical and hospital expenses of donor when the expenses are not covered by the donor's insurance and when the transplant recipient is a HealthAmerica member approved for transplant services. Solid organ transplants limited to:	15% coinsurance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Cornea • Heart • Heart/lung • Kidney • Liver • Pancreas* • Kidney/Pancreas • Lung: single, double • Intestinal transplants - small intestine - small intestine with the liver - small intestine with multiple organs such as the liver, stomach, and pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis. * We limit the coverage for pancreas (only) transplants to patients who have insulin dependent (or Type 1) diabetes mellitus when we find that exogenous treatment with insulin is ineffective.	15% coinsurance
These tandem **blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other Services* in Section 3 for prior authorization procedures. These transplants are limited to the stages of the following diagnoses. The medical necessity is considered satisfied if the patient meets the staging description. • Autologous tandem transplants for: - Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	15% coinsurance
These **blood or marrow stem cell transplants** are not subject to medical necessity review by the Plan. These blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians measure many features of leukemia or lymphoma cells to gain insight into its aggressiveness or likelihood of response to various therapies. Some of these include the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells can grow. These analyses may allow physicians to determine which diseases will respond to chemotherapy or which ones will not respond to chemotherapy and may require a transplant. Allogeneic (donor) transplants for: • Acute lymphocytic or non-lymphocytic leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)	15% coinsurance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Acute myeloid leukemia • Advanced Myeloproliferative Disorder (MPDs) • Advanced Neuroblastoma • Amyloidosis • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, pure red cell aplasia) • Mucolipidosis (e.g. Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g. Hunter's Syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteauxlamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic / Hemophagocytic deficiency diseases (e.g. Wiskott-Aldrich syndrome) • Severe combined immuno-deficiency disease • Severe or very severe aplastic anemia • Sickle cell anemia Autologous transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Amyloidosis • Advanced Neuroblastoma • Multiple Myeloma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	15% coinsurance
Mini Transplants performed in a clinical trial setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other Services* in Section 3 for prior authorization procedures: Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Acute myeloid leukemia	15% coinsurance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Advanced Myeloproliferative Disorder (MPDs) • Amyloidosis • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, pure red cell aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immuno-deficiency disease • Severe or very severe aplastic anemia Autologous transplants for: • Acute lymphocytic or non-lymphocytic leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed • Amyloidosis • Neuroblastoma • Breast cancer	15% coinsurance
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. These blood and marrow stem cell transplants are covered if the following are met: • The trial is a NCI and/ or NIH sponsored trial; or • The trial is conducted at an approved NCI center; and • The trial is approved by the Plan's Medical Director in accordance with the Plan's protocols. Allogeneic transplants for: • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma Mini-transplants (non-myeloblative allogeneic, reduced intensity conditioning or RIC) for • Acute lymphocytic or non-lymphocytic leukemia	15% coinsurance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast Cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple Myeloma • Multiple sclerosis • Myeloproliferative Disorder (MPDs) • Non-small lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia (pediatric only) Autologus Transplants for • Advanced Childhood kidney cancers • Advanced Ewing sarcoma • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast Cancer • Childhood rhabdomyosarcoma • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma /small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Mantle Cell (non-Hodgkin's lymphoma) • Multiple sclerosis • Small cell lung cancer • Systemic lupus erythematosus • Systemic sclerosis Coventry Transplant Network (CTN) - NOTE: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests and donor search expenses for the actual solid organ or up to four bone marrow /stem cell transplant donors in addition to the testing of family members.	15% coinsurance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
Not covered: • *Donor expenses related to donating organs or tissue to a non-member recipient.* • *Implants of artificial organs* • *Transplants not specifically listed as covered*	*All charges.*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	15% coinsurance
Professional services provided in – • Office	$25 per office visit to your Primary Care Physician $50 per office visit to a Specialist (No deductible)

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have a deductible under the Standard Option. The calendar year deductible the Standard Option is $750 per person ($1,500 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. Copayments for office visits do not count toward the calendar year deductible or out-of-pocket maximum.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require pre-certification.

Benefit Description	You pay After the calendar year deductible
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when it does not apply.	
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	15% coinsurance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen	15% coinsurance
• Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	15% coinsurance
Not covered: • *Custodial care*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible
Inpatient hospital (cont.)	
• *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care except when medically necessary*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma • Blood and blood plasma, if not donated or replaced • Packed red blood cells, cryoprecipitate, Factor VII, and platelets; • Other clotting factors or blood components such as Factor VIII or Factor IX, whether naturally or artificially derived are covered for acute traumatic events or when medically necessary. • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedure itself.	15% coinsurance
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
Skilled nursing facility (SNF) or Extended care benefits: 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 and approved by us. Services include: • 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	15% coinsurance
Not covered: Custodial care rest cures, domiciliary, or convalescent care	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services include inpatient and outpatient care, and family counseling. Hospice 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.	15% coinsurance
Not covered: Independent nursing, homemaker services	*All charges*

Benefit Description	You pay After the calendar year deductible
Ambulance	
Local professional ambulance service when medically appropriate	15% coinsurance

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have a deductible under the Standard Option. The calendar year deductible the Standard Option is $750 per person ($1,500 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. Copayments for office visits do not count toward the calendar year deductible or out-of-pocket maximum.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside our service area

If you experience the sudden onset of a medical condition or injury with symptoms that you think may result in serious impairment, please go to the nearest emergency room or call 911. Otherwise if your symptoms allow, call your Primary Care Physician. Your primary care physician is available to advise you about an urgent or emergency situation 24 hours a day, seven days a week by phone. Your PCP's phone number is on your ID card. Be sure to call your Primary Care Physician before going to a hospital emergency room or urgent care center whenever possible. If it is not possible, go straight to the nearest hospital emergency room or call 911 or the local emergency phone number. Be sure to tell the emergency room personnel that you are a HealthAmerica Plan member. Please be sure that you contact your PCP within 24 hours of being treated or admitted. Your PCP will make sure that:

- Medical information about you is given to the hospital emergency room doctor;
- Your care continues without delay; and
- Your follow-up care is coordinated.

If you are outside the service area and a Plan doctor believes that your 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.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when it does not apply.	
Emergency within our service area	
• Emergency care at your primary care doctor's office	$25 per office visit (No deductible)
• Emergency care at a specialist's office	$50 per office visit (No deductible)
• Emergency care as an outpatient at a hospital • Emergency care as an outpatient at an urgent care center Note: We waive the ER copay if you are admitted to the hospital.	$125 per visit $50 per visit (No deductible)
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office	$25 per office visit (No deductible)
• Emergency care at a specialist's office	$50 per office visit (No deductible)
• Emergency care as an outpatient at a hospital or urgent care center • Emergency care as an outpatient at an urgent care center Note: We waive the ER copay if you are admitted to the hospital.	$125 per visit $50 per visit (No deductible)
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	15% coinsurance

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

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must use participating providers.
- We have a deductible under the Standard Option. The calendar year deductible the Standard Option is $750 per person ($1,500 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. Copayments for office visits do not count toward the calendar year deductible or out-of-pocket maximum.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional Services	
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
• Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits)	Nothing (no deductible)

Professional Services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Professional Services (cont.)	
• Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Nothing (no deductible)
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner - Lab tests such as blood tests, urinalysis, pathology - Xrays such as ultrasounds, electrocardiograms and EEG - High- end Radiology such as CAT scans, MRI, PET, CT	• Nothing (no deductible) • 15% coinsurance • $125 copay (no deductible)
• Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	15% coinsurance
• Inpatient diagnostic tests provided and billed by a hospital or other covered facility	15% coinsurance
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	15% coinsurance
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	15% coinsurance
Not covered	
• *Services we have not approved.* • *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.* • *Testing for learning disabilities, school related issues, or for the purposes of obtaining or maintaining employment.*	*All Charges*

Preauthorization

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

MHNet Behavioral Health will coordinate your Mental Health and Substance Abuse services. If you need help, call your Primary Care Physician. Your doctor will work with MHNet Behavioral Health to coordinate the care that you need. You may also call MHNet Behavioral Health directly without referral from your Primary Care Physician.

If you need to seek mental health care services on an emergency basis, MHNet Behavioral Health is available to you 24 hours a day, 7 days a week. Their normal business hours are from 8:00 a.m. to 5 p.m Monday through Friday. You can reach MHNet Behavioral Health toll free at (800) 369-8362, TDD (800)627-6684.

We have a comprehensive network of professionals and facilities available for mental health and chemical dependency treatment. If you need assistance with finding a provider call (866) 351-5946.

Limitation

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

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The Standard Option annual calendar year deductible does not apply to the prescription drug benefits. Copayments that you pay for covered prescription medication do not count toward the calendar year deductible or out-of-pocket maximum.
- Selected products and certain prescription drugs require our prior approval. In general, drugs that require our prior approval (1) are not suggested for first-line therapy, (2) require special tests before starting them, or (3) have very limited approval for use.
- **Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost- sharing works.** Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician or referral plan doctor must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a local Plan participating pharmacy or by mail at our participating mail-order pharmacy for a plan-approved maintenance medication. Our Plan pharmacies are listed in our directory.
- **We use a formulary.** Our Prescription Drug Formulary is a list of drugs and other items that we approve for your use and which will be dispensed through participating pharmacies to members. We periodically review and modify our formulary. The list of approved drugs is available for review in the participating physician's office. You may also obtain them formulary list by contacting the Plan's Member Services Department or our website at www.healthamerica.cvty.com. We cover non-formulary drugs prescribed by a Plan doctor.
- **These are the dispensing limitations.** You may obtain up to a 31-day supply or 100-unit supply; whichever is less, at a Plan Participating retail pharmacy. For commercially prepackaged drugs such as topicals, inhalers, and vials, you will pay one copay for each container. Selected products or prescription drugs may require prior approval from the Plan. These medications may include those that (1) are not suggested for first-line therapy, (2) may require special tests before starting them, (3) have very limited approval for use, or (4) have specific quantity limits. When generic substitution is permissible, but you or your doctor choose the name brand drug over the generic drug, you pay the price difference between the generic drug and name brand drug as well as the appropriate copay per prescription unit or refill. Your prescription drug copay will never exceed the retail price of the drug. Plan members called to active military duty (or members in time of national crisis) who need to obtain prescribed medications should call us at 866-351-5946.
- The Plan Administrator reserves the right to include only one manufacturer's product on the Drug Formulary when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers. The product that is listed on the Drug Formulary will be covered at the applicable copayment. The product or products not listed on the Drug Formulary will be excluded from coverage.
- The Plan Administrator reserves the right to include only one dosage or form of a drug on the Drug Formulary when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms (for example but not limitation, dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product in the dosage or form that is listed on the Drug Formulary will be covered at the applicable copayment. The product or products in other forms or dosages that are not listed on the drug Formulary will be excluded from coverage.

- **Prescriptions by Mail-order.** You can order up to a 3-month supply of Plan approved maintenance medications through the mail and pay just two times the retail pharmacy copay. For commercially prepackaged drugs such as topicals, inhalers, and vials, you will pay one mail order copay for each three (3) containers. Maintenance medications are those that you must take for long-term conditions such as high blood pressure or high cholesterol. Simply ask your doctor to write your maintenance medication prescription for up to a 90-day supply. You will need to complete a mail order form (which you can obtain from Member Services) and mail it to the address on the front of the envelope. Not all maintenance medications are available by mail-order. For a list of maintenance medications that you can obtain by mail, please contact us at (866) 351-5946.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name. The name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.
- The Plan Administrator reserves the right to limit the location at which a Plan Participant can fill a covered Prescription Order or Refill to a Pharmacy that is mutually agreeable to both the Claims Administrator and the Plan Participant. Such limitation may be enforced in the event that the Claims Administrator identifies an unusual pattern of claims for covered benefits.
- **When you do have to file a claim.** Prescription drugs prescribed for emergency services and filled by a Non-Participating pharmacy are covered only for a quantity sufficient to treat the acute phase of the illness/injury. Coverage for such prescription Drugs prescribed in relation to Emergency Services and provided by a Non-Participating pharmacy is limited to one hundred percent (100%) of the Reasonable and Customary Charge less applicable copayments and other appropriate charges as noted above such as when a brand drug is dispensed and an FDA approved generic is available. Members must submit claims for reimbursement of prescription drugs purchased from a Non-Participating pharmacy on a Direct Reimbursement Form (available from HealthAmerica's Member Services Department). All claims for reimbursement must be received by HealthAmerica or its agent within ninety (90) days of the date of purchase of the prescription drugs. Claim forms are also available from our website www.healthamerica.cvty.com under the Downloadable Rx Forms Section.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not Covered. • Full range of FDA approved contraceptives, including but not limited to oral, injectable or implantable contraceptives and contraceptive diaphragms • Insulin with a charge and copay for each vial • Plan approved diabetic supplies and pharmacological agents, or devices used to assist in insulin injection (injection aids) including insulin syringes and needles, blood glucose test strips and lancets • Disposable needles and syringes for the administration of covered medications • Self administered- injectable drugs (see note below). *Note:* Specialty Medication means the group of medications defined by the Claims Administrator that are typically high-cost drugs and include but are not limited to oral, topical, inhaled, inserted or implanted, and injected routes of administration. Specialty medications are designated as such in the member formulary. Included characteristics of Specialty Medications are by the following definitions and structure: • Drugs that are used to treat and diagnose rare or complex diseases	At a Plan Retail Pharmacy: $5 copay for Tier One (generic formulary), $35 copay for Tier Two (name brand formulary), $60 copay Tier Three (non-formulary) or **Through our Mail Order Pharmacy:** $10 copay for Tier One (generic formulary), $70 copay for Tier Two (name brand formulary), $120 copay for Tier Three (non-formulary)

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• Require close clinical monitoring and management • Frequently require special handling • May have limited access or distribution • Except in urgent situations, all specialy medications are distributed by a plan approved speciality pharmacy • Limited to no more than a 30 day supply • Require Prior Authorization unless specified elsewhere • Subject to quantity limits Specialty Pharmacy means a pharmacy that: • has a contract with the Plan, and • is designated as a Specialty Pharmacy by the Plan for Plan Participants to obtain Specialty Medications. Note: Please check section 5(a) when checking coverage for intravenous fluids and medications for home use, some injectable drugs, diabetic equipment (glucose monitor) and some FDA approved contraceptive devices.	At a Plan Retail Pharmacy: $5 copay for Tier One (generic formulary), $35 copay for Tier Two (name brand formulary), $60 copay Tier Three (non-formulary) or **Through our Mail Order Pharmacy:** $10 copay for Tier One (generic formulary), $70 copay for Tier Two (name brand formulary), $120 copay for Tier Three (non-formulary) Note: If there is no generic equivalent available, you will still have to pay the brand name copay. Note: For commercial containers through mail order, you pay the appropriate copay for each (3) containers.
• Drugs for sexual dysfunction are subject to dose or quantity limitations. If it comes in pill form the limit is 4 pills per month, or 6 units per month for injectables or suppositories. Call the Plan for specific dose limitations . Note: These drugs are not available by mail-order.	**At a Plan Pharmacy** $60 copay
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, and minerals (both OTC and legend), except legend prenatal vitamins and liquid or chewable legend pediatric vitamins* • *Supplies such as dressings and antiseptics* • *Drugs used for the primary purpose of treating infertility, including those given in connection with artificial insemination* • *Oral dental preparations and fluoride rinses* • *Drug therapy for weight loss (e.g. Xenical)* • *Nonprescription medicines*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• *Drugs for investigational and experimental purposes* • *Food or food supplements, other nutritional and over-the-counter electrolyte supplements.* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 27).	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employee Dental/Vision Insurance Program (FEDVIP) your FEHB Plan will be First Primary payor of any Benefit payments and your FEDVIP plan is secondary to your FEHB plan. See Section 9. Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We have a deductible under the Standard Option. The calendar year deductible the Standard Option is $750 per person ($1,500 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. Copayments for office visits do not count toward the calendar year deductible or out-of-pocket maximum.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- **Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost- sharing works.** Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay After the calendar year deductible
The calendar year deducutible applies to almost all Standard Option benefits in this section. We say "No Deductible" when it does not apply.	
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. We will only cover services that you receive within 24 hours of the accident. Note: We do not cover services rendered more than 24 hours after the accidental injury whether or not the treatment is a continuation or completion of a treatment plan initiated at time of injury.	15% coinsurance
Not covered: • *Services provided after the initial 24 hours post* • *Orthodontia and all other dental related services* • *Services provided by non-participating dentists* • *Other dental services shown as not covered.*	*All charges*
Dental Benefits	
We have no other dental benefits.	*All charges*

Section 5(h). Special features

Feature	Description
Feature	
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in this agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Services for deaf and hearing impaired	Telecommunications Device for the Deaf and hearing impaired members who have access to a TDD-Compatible telephone. Members call (800) 207-1262 from 7 am - 6 pm Monday- Friday or from 9 am - 1 pm on Saturday.
Complex case management	Complex Case Management programs promote quality of care to reduce the likelihood of extended, more costly health care. Our specially trained nurse case managers work directly with the patients and their doctors. Some of the programs include Cardiovascular, Endocrinology, Oncology, Trauma/Medical-Surgical.
High risk pregnancies	This program is set up to identify women at risk for developing complications that may affect their pregnancy. The program promotes quality of care to reduce the likelihood of extended, more costly health care and focus on patients at risk, early intervention, coordination of care between patient and health care team, continuing education and regular follow up to ensure the patient is following the plan of care properly. For more information call (866) 351-5946.

Feature - continued on next page

Feature	Description
Feature (cont.)	
Centers of excellence	HealthAmerica has a nationally recognized organ transplant network through Coventry's Transplant Centers of Excellence to coordinate care for members who may need a transplant. The network provides you and your family with access to the hospitals across the country, which specialize in specific transplant procedures. For information and access to these Centers of Excellence call Member Services. Care provided outside the Centers of Excellence network will not be covered unless approved by the Plan.
Student out-of-area coverage	Limited coverage is available to dependent students up to the age of 26 who: • are the dependents of Federal Government subscribers who live in the HealthAmerica service area. • attend a secondary school, college, university or licensed trade school full time; (must submit a copy of schedule or a letter from the school stating the students full time status and • temporarily live outside Pennsylvania, but in the USA for the purpose of attending school; This limited benefit provides coverage outside Pennsylvania at non-participating providers for the treatment of an unexpected illness or injury. Covered benefits include such things as: emergency care, physician services for illness and injury, outpatient rehabilitation, diabetic education and training, therapeutic injections, dialysis, lab, radiology, durable medical equipment and corrective appliances, allergy serum and services, initial doctor visit to diagnose a pregnancy. Some benefits require authorization. Benefits Not Covered: Any benefit not listed above as a covered benefit; any benefit no considered to be medically necessary; elective care service. Additionally, mental health and substance abuse services must be provided by a participating provider. When in the HealthAmerica service area, students must use participating providers. Dependent student coverage is subject to the Exclusions and Limitations as outlined in this brochure. If you have questions please contact the Plan at 1-866-351-5946.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan. For additional information contact the Plan at 866-351-5946 or visit the website at www.healthamerica.cvty.com.

Dental Care

We offer preventive dental coverage to HealthAmerica members. See enclosed materials or visit our website for more information.

Vision Coverage

EyeMed Vision Care offers immediate savings on your eye care needs including eyeglass frames and lenses. There are thousands of EyeMed Vision Care network provides including Sears Optical, Target Optical, Pearle Vision, JCPenny Optical and select Independent Doctors of Optometry.

Kids Health

This program helps families make informed decisions about children's health. Includes age-appropriate content for parents, kids and teens.

Health Education Classes

Classes include Weight Management, Diabetic Education, Prenatal Education, Stress Management and Smoking Cessation. You can be reimbursed up to $350 per calendar year for the Weight Watchers program when you have attended 80% of the meetings.

Childhood Obesity Education - for additional information, visit the Wellness section of our website at http://healthamerica.coventryhealthcare.com/wellness-resources/index.htm

To obtain an approved listing of programs available call our customer service department at (866) 351-5946. Or you can receive additional information regarding any of our programs by accessing the HealthAmerica website at www.healthamerica.cvty.com.

Health insurance for individuals and families:

The One that simply makes sense

Coventry*One*® and the Coventry*One* family of brands, including HealthAmerica*One*, is health insurance for individuals and families with a variety of affordable options that make it easy to choose a plan that's comfortable for you.

HealthAmerica*One* has affordable, comprehensive health care coverage that's right for individuals and families in all stages of life: recent graduates, families and self –employed to name a few. It offers a variety of affordable individual and family health insurance plan option to meet the coverage and budget demands you face every day. HealthAmerica*One* plans are easy to use and ideal for those who do not have access to group health care coverage. Check out our website to learn more about our health insurance for individuals and families.

Click on *Get A Quote* on healthamericaone.com or contact us at 1-866-Why-Worry (1-866-949-9677).

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits.There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergencyservices/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care costs for clinical transplant trials; this includes costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs for clinical transplant trials; this includes costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at (866) 351-5946, or at our website at healthamerica.coventryhealthcare.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

If you are in enrollment code SW and PN, submit your claims to:

Harrisburg - HealthAmerica, Attn: Member Services Department, PO Box 7088, London, KY 40742

Prescription drugs

You must complete a claim reimbursement form. Contact the Plan at (866) 351-5946.

Deadline for filing your claim

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

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.healthamerica.cvty.com and login to *My Group Benefits username and password is 100001.*

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

1 Ask us in writing to reconsider our initial decision. You must:

a. Write to us within 6 months from the date of our decision; and

b. Send your request to us at the address below which is based on your enrollment code:

Central Region (SW)

HealthAmerica, Attn: Member Services Department,

3721 TecPort Drive

P.O. Box 67103

Harrisburg, PA 17106;

and

c. Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d. Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e. Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2

In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (866)-351-5946. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), TTY (1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, TTY (1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You can also sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Tell us if you are enrolled in Medicare part A or B. Medicare will determine who is responsible for paying first for medical services. If Medicare pays first, we coordinate our payment for covered services as long as you use providers that are part of our network. Under your FEHB coverage, we do not waive any of the copayments.

Claims process when you have the Original Medicare Plan - You will probably not need to file a claim form when you have both our Plan and the Original Medicare plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at (866) 351-5946 or see our Web site at www.healthamerica.cvty.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

You can find more information about how our plan coordinates benefits with Medicare, please visit our website at www.healthamerica.cvty.com and login to *My Group Benefits*. The *My Group Benefits* username and password is 100001.

- **Tell us about yout Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary / secondary status of this plan and Medicare.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), TTY (1-877-486-2048) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

  This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage

  This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but **we will not waive any of our copayments, coinsurance, or deductibles**. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

- **Medicare prescription drug coverage (Part D)**

  When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for your injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as you primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – are covered within the context a clinical trial is approved by the health plan. Costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. **This plan does not cover these costs.**
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. **This plan does not cover these costs.**

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical Trials Cost Categories	• Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. • Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. • Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial Care	Care provided by non-medical personnel that does not attempt to cure your condition but will help you perform daily living activities. Some examples of custodial care include helping you walk, dress, bathe, eat or take your medication.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 13.
Experimental or investigational service	We gather appropriate information to determine whether a procedure, service, or supply is experimental or investigational. The gathered information includes all appropriate medical records, reviews of current medical and scientific evidence publications, as well as information from government regulatory bodies. Appropriate medical professionals participate in the extensive evaluation process to determine whether a procedure is/is not considered experimental or investigational. After the determination is made, you will be notified of our decision. You can obtain a copy of our Experimental procedures Determinations Policy by contacting the Plan.
Group health coverage	Group health coverage is protection that provides payment of benefits for covered sickness or injury.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medical necessity	A service or treatment which is appropriate and consistent with diagnoses, and which in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered.
Morbid Obesity	A body mass index (BMI) more than 40 or a BMI greater than 35 with documented co morbid conditions such as cardiopulmonary problems (e.g., severe apnea), Pickwickian Syndrome, obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis.

Out-of-pocket maximum The out-of-pocket maximum is an annual limit on the amount of coinsurance that you must pay for covered services. This limit does not include office visit or prescription drug copays.

Plan allowance Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. When services are received at participating providers, payment will be made to the provider for services rendered, based on the contract we have with the provider.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Primary Care Physician Primary Care Physician (PCP) is a family practitioner, internist or a pediatrician. Your PCP can provide most of your routine care and will manage your preventive care.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Urgent care claims A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-866-351-5946. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refer to HealthAmerica Pennsylvania, Inc.

You You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- 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
- What happens when your enrollment ends
- When the next open season for enrollment begins

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

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of any changes in family status, including your marriage, divorce, annulment, or when your child reaches age 26.

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

Family member coverage

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but NOT their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2012 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2011 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

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

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Section 12. Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contirbute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care (LEX HCFSA)**-Designated for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA** Reimburses you for eligible **non medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9p.m., Eastern Time. TTY:1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program, and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888- 3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living- such as bathing or dressing yourself- or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (call underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY1-800-843-3557) or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

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Summary of benefits for the Standard Option of HealthAmerica Pennsylvania, Inc. - 2012

- Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the calendar year deductible of $750 Self only and $1,500 Self and Family.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $25 primary care; $50 specialist	20
Services provided by a hospital:		
• Inpatient *	15% coinsurance	38
• Outpatient *	15% coinsurance	39
Emergency benefits:		
• In-area	$125 per hospital emergency room visit $50 per urgent care center visit	41
• Out-of-area	$125 per hospital emergency room visit $50 per urgent care center visit	41
Mental health and substance abuse treatment:	Regular cost-sharing	43
Prescription drugs:		46-47
• Retail pharmacy	$5 generic formulary; $35 name brand formulary; $60 non-formulary	46-47
• Mail order	$10 generic formulary; $70 name brand formulary; $120 non-formulary	46-47
Dental care: Accidental injury benefit only for care rendered within 24 hours*	15% coinsurance	50
Vision care: Limited to one annual eye refraction for children up to age 18 only	$15 per office visit	25
Special features: Flexible Benefit Options, Member Services TDD, Complex Case Management, High risk pregnancy, Centers of Excellence, Student Out-of-Area Benefits		51
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $4,750 Self only or $9,500 Self and Family. Some costs do not count toward this protection.	15

2012 Rate Information

For 2012 health premium information, please see http://www.opm.gov/insure/health/tribes/rates/ or contact your tribe's Human Resources department.