



# HealthAmerica Pennsylvania, Inc.

# 2001

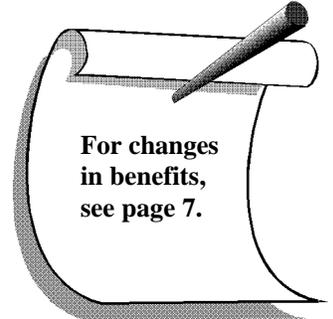
<http://www.healthamerica.cvtv.com>

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## A Health Maintenance Organization

**Serving:** *Greater Pittsburgh Area, Central, South Central & Northeast Pennsylvania*

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



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

### Enrollment codes for this Plan:

**Greater Pittsburgh Area**  
**261 Self Only**  
**262 Self and Family**

**Central, South Central & Northeast Pennsylvania**  
**SW1 Self Only**  
**SW2 Self and Family**

Authorized for distribution by the:



UNITED STATES  
OFFICE OF PERSONNEL MANAGEMENT  
RETIREMENT AND INSURANCE SERVICE  
[HTTP://WWW.OPM.GOV/INSURE](http://www.opm.gov/INSURE)



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## Introduction

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HealthAmerica Pennsylvania, Inc.  
2575 Interstate Drive  
Harrisburg, PA 17110

This brochure describes the benefits of HealthAmerica Pennsylvania, Inc. under our contract (CS 2078) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

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## Plain Language

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

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

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

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## Section 1. Facts about this HMO plan

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

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

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

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

### How we pay providers

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

### Who provides my health care?

We are a mixed-model HMO with physicians in individual or group practices. You and each covered family member must choose a Primary Care Physician (PCP) who specializes in family practice, internal medicine, or pediatrics. Your PCP will provide or coordinate all of your health care needs.

### Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website ([www.opm.gov/insure](http://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; licensed since 1975.
- We have over 25 Years in existence.
- We are a for-profit HMO.
- We have participated with the FEHB program since 1977.

If you want more information about us, call 1-800-735-4404 for the Greater Pittsburgh region, or 1-800-788-8445 in Central, South Central and Northeast Pennsylvania, or write to 2575 Interstate Drive, Harrisburg, PA 17110. You may also contact us by visiting our website at [www.healthamerica.cvty.com](http://www.healthamerica.cvty.com).

## **Service Area**

You must live in our service area to enroll with us. Our service area is where our providers practice. You must enroll in the code we have designated for your county.

Enrollment code 26 (Greater Pittsburgh area) includes the following Pennsylvania counties:

- Allegheny
- Armstrong
- Beaver
- Butler
- Cambria
- Fayette
- Greene
- Indiana
- Lawrence
- Mercer
- Somerset
- Washington
- Westmoreland

Enrollment code SW (Central, South Central, Northeast Pennsylvania) includes the following Pennsylvania counties:

- Adams
- Berks
- Blair
- Centre
- Clinton
- Columbia
- Cumberland
- Dauphin
- Huntingdon
- Juniata
- Lancaster
- Lebanon
- Luzerne
- Lycoming
- Mifflin
- Northumberland
- Perry
- Schuylkill
- Snyder
- Union
- York

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## Section 2. How we change for 2001

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### Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our *plan network* will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling Member Services at 1-800-735-4404 in Greater Pittsburgh; or 1-800-788-8445 in Central, South Central, and Northeast Pennsylvania **or** checking our website [www.healthamerica.cvtv.com](http://www.healthamerica.cvtv.com). You can find out more about patient safety on the OPM website, [www.opm.gov/insure](http://www.opm.gov/insure). To improve your healthcare, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

### Changes to this Plan

- If you are in Enrollment Code 26, your share of the non-postal premium will increase by 6.1% for Self Only or 6.1% for Self and Family. If you are in enrollment code SW, your share of the non-postal premium will increase by 5% for Self Only or decrease by 7.6% for Self and Family.
- The office visit copay has changed from \$10 to \$15 for all specialty care visits.
- Your copays have increased under the Prescription Drug Benefits. You now pay \$8 for Generic Formulary drugs, \$14 for Name Brand Formulary drugs, or \$35 for Non-formulary drugs from Plan retail pharmacies. See page 32.
- You may obtain up to a 90-day supply of maintenance medication by Mail order after you pay a \$16 copay for Generic Formulary drugs, \$28 copay for Name Brand Formulary drugs or a \$70 copay for Non-formulary drugs.
- Your Emergency Room copay has increased from \$25 to \$35 for each emergency room visit or urgent care visit.

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## Section 3. How you get care

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### Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-735-4404 in Greater Pittsburgh; or 1-800-788-8445 in Central, South Central, and Northeast Pennsylvania.

### Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, and you will not have to file claims.

- **Plan providers**

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

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

- **Plan facilities**

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

### What you must do

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

If you need to see a specialist, your PCP will coordinate this care. Your PCP has relationships with specialists, hospitals and other medical providers. Each visit to a specialist must be arranged by your PCP. Your PCP may be able to provide you with needed follow up care after your specialist visit. Your primary care physician will refer you to a specialist for needed care.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary

care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - reduce our service area and you enroll in another FEHB Plan,

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

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

#### • Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-735-4404 for the Greater Pittsburgh region, or 1-800-788-8445 in Central, South Central and Northeast Pennsylvania. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the benefits of the hospitalized person.

## **Circumstances beyond our control**

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

## **Services requiring our prior approval**

Your primary care physician has authority to refer you for most services. For certain medical procedures, tests or when sending you to a hospital 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 precertification:

- inpatient hospital admissions,
- outpatient surgeries,
- home health care,
- durable medical equipment,
- out of network referral requests,
- transplant requests,
- complex diagnostic testing such as Magnetic Resonance Imaging,
- chiropractic care,
- rehabilitative service,
- infertility treatment and
- oral surgery.

You must contact Mainstay/Magellan before seeking mental health and substance abuse treatment. Mainstay/Magellan will help develop a treatment plan that you must follow. We will not cover services that the have not approved.

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## **Section 4. Your costs for covered services**

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

- **Copayments**

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

Example: When you see your primary care physician you pay a copayment of \$10 per office visit and when you see a specialist you pay a \$15 copay per office visit.

- **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before benefits are paid. We do not have a deductible.

- **Coinsurance**

Coinsurance is the percentage of negotiated fee that you pay for your care. In our plan, you pay a \$300 copay or 50% of the cost, whichever is less, for infertility services.

## **Your out-of-pocket maximum**

Your out of pocket expenses for benefits covered under this Plan are limited to the stated copayments and coinsurance required for some benefits.

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## Section 5. Benefits – OVERVIEW

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

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**NOTE:** This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-735-4404 for the Greater Pittsburgh region, or 1-800-788-8445 in Central, South Central and Northeast Pennsylvania or at our website at [www.healthamerica.cvty.com](http://www.healthamerica.cvty.com).

(a) Medical services and supplies provided by physicians and other health care professionals .....	12-19
• Diagnostic and treatment services	• Hearing services (testing, treatment, and supplies)
• Lab, X-ray, and other diagnostic tests	• Vision services (testing, treatment, and supplies)
• Preventive care, adult	• Foot care
• Preventive care, children	• Orthopedic and prosthetic devices
• Maternity care	• Durable medical equipment (DME)
• Family planning	• Home health services
• Infertility services	• Alternative treatments
• Allergy care	• Educational classes and programs
• Treatment therapies	
• Rehabilitative therapies	
(b) Surgical and anesthesia services provided by physicians and other health care professionals .....	20-23
• Surgical procedures	• Oral and maxillofacial surgery
• Reconstructive surgery	• Organ/tissue transplants
	• Anesthesia
(c) Services provided by a hospital or other facility, and ambulance services .....	24-26
• Inpatient hospital	• Extended care benefits/skilled nursing care facility benefits
• Outpatient hospital or ambulatory surgical center	• Hospice care
	• Ambulance
(d) Emergency services/accidents .....	27-28
• Medical emergency	• Ambulance
(e) Mental health and substance abuse benefits .....	29-31
(f) Prescription drug benefits .....	32-34
(g) Special features .....	34
• <i>High-risk pregnancy, Centers of Excellence, Member Services TDD, Case Management</i>	
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## Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Benefit Description	You pay
<b>Diagnostic and treatment services</b>	
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> </ul>	\$10 per office visit to your Primary Care Physician \$15 per office visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> <li>• Initial examination of a newborn child covered under a family enrollment</li> </ul>	Nothing
Professional services of physicians after posted office hours	\$20 per office visit to your Primary Care Physician \$30 per office visit to a Specialist
At home	\$10 per visit by Primary Care Physician \$15 per visit by Specialist

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine Mammograms</li> <li>• Cat Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	Nothing if you receive these services during your office visit; otherwise, \$10 per office visit to your Primary Care Physician or \$15 per office visit to a Specialist
Preventive care, adult	
Routine screenings, such as: Blood lead level – One annually <ul style="list-style-type: none"> <li>• Total Blood Cholesterol – once every three years, ages 19 through 64</li> <li>• Colorectal Cancer Screening, including               <ul style="list-style-type: none"> <li>•• Fecal occult blood test</li> </ul> </li> </ul>	Nothing if you receive these services during your office visit; otherwise, \$10 per office visit to your Primary Care Physician or \$15 per office visit to a Specialist
<ul style="list-style-type: none"> <li>•• Sigmoidoscopy, screening – every five years starting at age 50</li> </ul>	Nothing
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	Nothing
Routine pap test Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i> , above.	\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist
Routine mammogram –covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• One per calendar year age 40 and above</li> </ul>	Nothing
<i>Not covered: Physical exams, immunizations or other services required for obtaining or continuing employment or insurance, attending schools camp, travel, driver’s license, marriage license or obtain a passport.</i>	<i>All charges</i>
Routine Immunizations, such as: <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza/Pneumococcal vaccines, annually, age 65 and over</li> </ul>	\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist

Preventive care, children	You pay
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist
<ul style="list-style-type: none"> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>•• Eye exams through age 17 to determine the need for vision correction to diagnose and treat diseases of the eye.</li> <li>•• Ear exams through age 17 to determine the need for hearing correction Hearing exams are limited to one per year.</li> <li>•• Examinations done on the day of immunizations (through age 22)</li> </ul> </li> <li>• Well-child care charges for routine examinations, immunizations and care (through age 22)</li> </ul>	\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see page xx for other circumstances, such as extended stays for you or your baby.</li> <li>• 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.</li> <li>• 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.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</li> </ul>	\$10 per office visit to your primary care physician or \$15 per office visit to a specialist Note: You pay the office visit copay for your first visit only. We waive the office visit copay after your initial maternity care visit.
<i>Not covered: Routine sonograms to determine fetal age, size or sex</i>	<i>All charges</i>
Family planning	
<ul style="list-style-type: none"> <li>• Voluntary sterilization</li> <li>• Injectable contraceptive drugs</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragm (fitting only)</li> </ul>	\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist
<i>Not covered: reversal of voluntary surgical sterilization</i>	<i>All charges.</i>

Infertility services	You pay
Diagnosis and treatment of infertility, such as: <ul style="list-style-type: none"> <li>• Artificial insemination:               <ul style="list-style-type: none"> <li>•• <i>intravaginal insemination (IVI)</i></li> <li>•• <i>intracervical insemination (ICI)</i></li> <li>•• <i>intrauterine insemination (IUI)</i></li> </ul> </li> </ul>	\$300 copay or 50% of the cost of the service, whichever is less
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Fertility drugs</i></li> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>•• <i>in vitro fertilization</i></li> <li>•• <i>embryo transfer, GIFT, ZIFT and ovum harvest</i></li> </ul> </li> <li>• <i>Services and supplies related to excluded ART procedures</i></li> <li>• <i>Cost of donor sperm</i></li> </ul>	<i>All charges.</i>
Allergy care	
Testing and treatment Allergy injection	\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist
Allergy serum	Nothing
<i>Not covered: provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>
Treatment therapies	
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 23. <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – Hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> Note: We will only cover GHT when we preauthorize the treatment and determine that it is medically necessary. Your doctor will need to submit medical information to support that GHT is medically necessary. You must obtain authorization for GHT before you begin treatment because we only cover GHT services from the date we determine it is medically necessary We do not cover GHT or related services and supplies if we determine it isn't medically necessary. See Services requiring our prior approval in Section 3.	\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist

Rehabilitative therapies	You pay
<p>Physical therapy, occupational therapy and speech therapy —</p> <ul style="list-style-type: none"> <li>• Up to two consecutive months per condition, per contract year for the services of each of the following: <ul style="list-style-type: none"> <li>•• qualified physical therapists;</li> <li>•• speech therapists; and</li> <li>•• occupational therapists.</li> </ul> </li> </ul> <p>Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury and if significant improvement can be expected within two consecutive months.</p> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to two consecutive months per condition, per contract year.</li> </ul>	<p>\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>long-term rehabilitative therapy or beyond two consecutive months per condition</i></li> <li>• <i>exercise programs</i></li> <li>• <i>Physical, occupational and speech therapy for developmental delay</i></li> </ul>	<p><i>All charges.</i></p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> <li>• Hearing testing</li> </ul>	<p>\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>all other hearing testing</i></li> <li>• <i>hearing aids, testing and examinations for them</i></li> </ul>	<p><i>All charges.</i></p>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> <li>• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> </ul>	<p>Nothing</p>
<ul style="list-style-type: none"> <li>• Annual eye refractions</li> </ul> <p>Note: You must contact National Vision Administrators (NVA) prior to your exam. NVA will send you a list of participating eye doctors and a vision claim form. Call NVA at 800-672-7723.</p>	<p>\$15 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Eyeglasses or contact lenses</i></li> <li>• <i>Eye exercises and orthoptics</i></li> <li>• <i>Radial keratotomy and other refractive surgery</i></li> </ul>	<p><i>All charges</i></p>

Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$15 per office visit to a Specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, reduction of warts, removal of toenails (except medically necessary surgery for ingrown toenails) and similar routine treatment of conditions of the foot, except as stated above</i></li> <li>• <i>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)</i></li> </ul>	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes;</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</li> <li>• 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.</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome when TMJ is caused by acute traumatic dislocation, fractures, neoplasms, rheumatoid arthritis, ankylosing spondylitis, or disseminated lupus erythematosus.</li> </ul> <p>Note: You must receive our preauthorization. Call us at 800/735-4404 for the Greater Pittsburgh region or 800/788-8445 in South Central, Central and Northeast Pennsylvania 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.</p>	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$15 per office visit to a Specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>orthopedic and corrective shoes</i></li> <li>• <i>arch supports</i></li> <li>• <i>foot orthotics (except for diabetics)</i></li> <li>• <i>heel pads and heel cups</i></li> <li>• <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li>• <i>Cochlear implant devices</i></li> <li>• <i>Replacement due to neglect</i></li> <li>• <i>Any dental care involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome or joint disorders.</i></li> <li>• <i>Dental prosthesis</i></li> <li>• <i>Lumbar Supports</i></li> <li>• <i>Wigs</i></li> </ul>	<p><i>All charges</i></p>

Durable medical equipment (DME)	You pay
<ul style="list-style-type: none"> <li>• Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: hospital beds;</li> <li>• wheelchairs; base model necessary to cover the needs of the member</li> <li>• crutches;</li> <li>• walkers;</li> <li>• Diabetes equipment such as blood glucose monitors, insulin infusion devices, and orthotics</li> </ul> <p>Note: You must receive our preauthorization. Call us at 800/735-4404 for the Greater Pittsburgh region or 800/788-8445 in South Central, Central and Northeast Pennsylvania 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.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Disposable items such as incontinent pads, catheters, irrigation kits, electrodes, ace bandages, elastic stockings and dressings</i></li> <li>• <i>Air conditioners</i></li> <li>• <i>Humidifiers</i></li> <li>• <i>Electric air cleaners</i></li> <li>• <i>Exercise or fitness equipment</i></li> <li>• <i>Elevators</i></li> <li>• <i>Hot tubs</i></li> <li>• <i>Hoyer lifts</i></li> <li>• <i>Shower/bath bench</i></li> <li>• <i>Routine servicing, e.g., testing, cleaning, regulating and checking of equipment.</i></li> <li>• <i>Special clothing of any type</i></li> <li>• <i>Hearing devices of any type</i></li> <li>• <i>Replacement due to neglect.</i></li> </ul>	<i>All charges</i>

Home health services	You pay
<ul style="list-style-type: none"> <li>• 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. In order for us to cover home health care you must receive preauthorization.</li> <li>• Services include oxygen therapy, intravenous therapy and medications.</li> </ul>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li>• <i>nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i></li> <li>• <i>Homemaker services</i></li> <li>• <i>Services or supplies furnished by a person who is the spouse or relative of member or by non home health provider</i></li> </ul>	<i>All charges.</i>
Alternative treatments	
Chiropractic Services – 15 visits per member per calendar year.	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>naturopathic services</i></li> <li>• <i>acupuncture</i></li> <li>• <i>hypnotherapy</i></li> <li>• <i>biofeedback</i></li> </ul>	<i>All charges.</i>
Educational classes and programs	
<p>Outpatient diabetes self-management training and education (including nutritional therapy) for persons with diabetes, when prescribed by a Plan Physician. Coverage includes:</p> <ul style="list-style-type: none"> <li>• visits medically necessary upon the diagnosis of diabetes;</li> <li>• 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</li> <li>• 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.</li> </ul>	<p>\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist</p>

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- Your Plan physician must get precertification of some surgical procedures. Please refer to the preauthorization information in Section 3 for a list of services.

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Benefit Description	You pay
<b>Surgical procedures</b>	
<ul style="list-style-type: none"> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedure</li> <li>• Biopsy procedure</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see reconstructive surgery)</li> <li>• Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over or Body Mass Index (BMI) is greater than 40.</li> <li>• Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.</li> </ul>	Nothing

*Surgical procedures continued on next page.*

<b>Surgical procedures</b> <i>(continued)</i>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Voluntary sterilization such as tubal ligation and vasectomy</li> </ul>	\$50 copay for vasectomy \$100 for tubal ligation
<ul style="list-style-type: none"> <li>• Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a).</li> <li>• Treatment of burns</li> </ul>	\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization, surgically-induced sterility</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care.</i></li> <li>• <i>Cosmetic procedures</i></li> </ul>	<i>All charges</i>
<b>Reconstructive surgery</b>	
<p>Surgery to correct a functional defect</p> <ul style="list-style-type: none"> <li>• Surgery to correct a condition caused by injury or illness if:               <ul style="list-style-type: none"> <li>•• the condition produced a major effect on the member's appearance and</li> <li>•• the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>• All stages of breast reconstruction surgery following a mastectomy, such as:               <ul style="list-style-type: none"> <li>•• surgery to produce a symmetrical appearance on the other breast;</li> <li>•• treatment of any physical complications, such as lymphedemas;</li> <li>•• breast prostheses and surgical bras and replacements (see Prosthetic devices)</li> </ul> </li> </ul> <p>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.</p>	See above.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>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</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<i>All charges</i>

Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate.</li> <li>• Excision of lesions of the mandible, mouth, lip, or tongue</li> <li>• Incision of accessory sinuses, mouth, salivary glands or duct;</li> <li>• Manipulation of dislocations of the jaw</li> <li>• Reconstruction or repair of the mouth or lips necessary to correct functional impairment caused by congenital condition and birth abnormalities;</li> <li>• Treatment of malignant tumors</li> <li>• Extractions of impacted third molars when partially or totally covered by bone.</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> <li>• <i>Orthodontia</i></li> <li>• <i>Treatment of TMJ if dental related</i></li> <li>• <i>Orthognathic or prognathic surgery when it is performed only to improve the appearance of a functioning structure.</i></li> </ul>	<p><i>All charges</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single–Double</li> <li>• Pancreas</li> <li>• Allogeneic (donor) bone marrow transplants</li> <li>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> </ul> <p>Note: Transplant services must be provided at a participating Center of Excellence as we determine. All transplants must be performed at specific hospitals that we approve and designate to perform the specific transplant procedure.</p> <p>Note: We cover related medical and hospital expenses of the 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.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Donor expenses related to donating organs or tissue to a non-member recipient</i></li> <li>• <i>Implants of artificial organs</i></li> </ul>	<i>All charge</i>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> </ul>	Nothing
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Office</li> </ul>	<p>\$10 per office visit to your Primary Care Physician</p> <p>\$15 per office visit to a Specialist</p>

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR PLAN PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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Benefit Description	You pay
<b>Inpatient hospital</b>	
<p>Room and board, such as</p> <ul style="list-style-type: none"> <li>• ward, semiprivate, or intensive care accommodations;</li> <li>• general nursing care; and</li> <li>• meals and special diets.</li> </ul> <p>NOTE: We will cover a private room provided when it is medically necessary. If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	Nothing
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Administration of blood and blood products</li> <li>• Blood or blood plasma, if not donated or replaced</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)</li> </ul>	Nothing

*Inpatient hospital continued on next page.*

<b>Inpatient hospital (continued)</b>	<b>You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes, extended care facilities, schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care</li> </ul>	<p><i>All charges</i></p>
<b>Outpatient hospital or ambulatory surgical center</b>	
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Packed red blood cells, cryoprecipitate, Factor VII, and platelets;</li> <li>• 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 Medically Necessary.</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>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.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• blood and blood derivatives replaced by the member</li> </ul>	<p><i>All charges</i></p>
<b>Extended care benefits/skilled nursing care facility benefits</b>	
<p>Skilled nursing facility (SNF) or Extended care benefits:</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Bed, board and general nursing care</li> <li>• Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor</li> </ul>	<p>Nothing</p>
<p><i>Not covered: custodial care, rest cures, domiciliary or convalescent care</i></p>	<p><i>All charges</i></p>

<b>Hospice care</b>	<b>You pay</b>
<p>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.</p>	Nothing
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<i>All charges</i>
<b>Ambulance</b>	
<ul style="list-style-type: none"> <li>Local professional ambulance service when medically appropriate</li> </ul>	Nothing

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We do not have a calendar year deductible
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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### 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.

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### What to do in case of emergency 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
<b>Emergency within our service area</b>	
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	\$10 per office visit during posted office hours or \$20 after posted office hours
<ul style="list-style-type: none"> <li>Emergency care at a Specialist office</li> </ul>	\$15 during posted office hours or \$30 copay after posted hours
<ul style="list-style-type: none"> <li>Hospital emergency room or urgent care center treatment</li> </ul>	\$35 copay per visit
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
<b>Emergency outside our service area</b>	
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	\$10 per office visit during posted office hours or \$20 after posted office hours
<ul style="list-style-type: none"> <li>Emergency care at a specialist's office</li> </ul>	\$15 during posted office hours or \$30 after posted hours
<ul style="list-style-type: none"> <li>Hospital emergency room or urgent care center treatment</li> </ul>	\$35 copay per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All charges</i>
<b>Ambulance</b>	
Professional ambulance service when medically appropriate. Air ambulance See 5(c) for non-emergency service.	Nothing

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

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**Parity**

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

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU CAN COORDINATE YOUR CARE THROUGH YOUR PRIMARY CARE PHYSICIAN OR DIRECTLY THROUGH MAINSTAY/MAGELLAN.** See the instructions after the benefits description below.

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Benefit Description	You pay
<b>Mental health and substance abuse benefits</b>	
<p>All Diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul> <p>Note: Psychiatrists, Psychologists, or clinical social workers are specialty providers. The office visit copay for specialists applies to services from these providers.</p>	<p>\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist Nothing for inpatient services</p>

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

Mental health and substance abuse benefits <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>Diagnostic tests</li> </ul>	\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist Nothing for inpatient services
<ul style="list-style-type: none"> <li>Services provided by a hospital or other facility</li> <li>Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	\$10 per office visit to your Primary Care Physician \$15 per office visit to a Specialist Nothing for inpatient services
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Services we have not approved.</i></li> <li><i>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.</i></li> <li><i>Testing for learning disabilities, school related issues, or for the purposes of obtaining or maintaining employment.</i></li> </ul> <p>Note: OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</p>	<p><i>All charges</i></p>

**Preauthorization**

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

We have a comprehensive network of professionals and facilities available for mental health and chemical dependency treatment. Please refer to the list of providers in the Mental Health/Chemical Dependency section of your Provider Directory. If you need a directory or assistance with finding a provider call Western Pennsylvania (800)-735-4404 or Eastern Pennsylvania (800)-788-8445 or (717) 540-6315.

Mainstay/Magellan Behavior Health coordinates your Mental Health and Substance Abuse services. If you need help, call your Primary Care Physician. Your doctor will coordinate your referral through Mainstay/Magellan. You may also call Mainstay/Magellan directly without referral from your primary care physician.

Mainstay/Magellan is available to you 24 hours a day. Their normal business hours are from 8:30 am to 4:00 pm. You can reach Mainstay/Magellan at (800)-669-7452 in Western Pennsylvania and (800)-332-1024 in Eastern Pennsylvania.

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**Special transitional benefit**

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

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

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

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***Limitation*** *We may limit your benefits if you do not follow your treatment plan.*

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## Section 5 (f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- We do not have a calendar year deductible.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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### 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 Plan participating pharmacy or by mail for a maintenance medication. Our Plan pharmacies are listed in our directory.
- **We use a formulary. It is a list of approved medications.** 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 web site at [www.healthamerica.cvty.com](http://www.healthamerica.cvty.com).
- **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. Sexual dysfunction drugs have pill limitations. When generic substitution is permissible, but you or your doctor request the name brand 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.
- **Prescriptions by Mail-Order.** You can order up to a 3-month supply of 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. (Examples of such conditions are high blood pressure or an estrogen hormone imbalance. 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 envelope (which you can obtain from Member Services) and mail it to the address on the front of the envelope. Unfortunately, all maintenance medications are not available by mail-order. If you have questions, please contact us at 800/735-4404 for the Greater Pittsburgh region or 800/788-8445 in South Central, Central and Northeast Pennsylvania.

*Prescription drug benefits begin on the next page.*

Benefit Description	You Pay
<p><b>Covered medications and supplies</b></p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except as excluded below.</li> <li>• Full range of FDA approved birth control, including but not limited to oral contraceptives, Depo Provera, and contraceptive diaphragms</li> <li>• Insulin with a charge and copay for each vial</li> <li>• 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</li> <li>• Selected injectables as specified by the Plan (Imitrex, Glucagon and Bee Sting Kits)</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Contraceptive drugs and devices</li> <li>• Norplant</li> <li>• Potassium Supplement to prevent/treat low potassium (prescription only)</li> </ul> <p>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.</p>	<p><b>At a Plan Retail Pharmacy:</b>  \$8 copay for generic formulary,  \$14 copay for name brand formulary,  \$35 copay non-formulary</p> <p>or</p> <p><b>Through our Mail Order Pharmacy:</b>  \$16 copay for generic,  \$28 copay brand,  \$70 copay for non-formulary</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>Note: For commercial containers thru mail order, you pay the appropriate copay for each (3) containers.</p>
<ul style="list-style-type: none"> <li>• Sexual dysfunction drugs have dispensing limitations and require prior approval. For complete details, please call Member Services using the phone number shown on your ID card.</li> </ul> <p>Note: These drugs are not available by mail-order.</p>	<p><b>At a Plan Retail Pharmacy:</b>  \$8 copay for generic formulary,  \$14 copay for name brand formulary,  \$35 copay non-formulary</p>
<p>Here are some things to keep in mind about our prescription drug program:</p> <ul style="list-style-type: none"> <li>• A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a FDA-approved generic drug is available, and you or your physician request the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.</li> <li>• We have an open formulary. If your physician believes a non-formulary product is necessary, your physician may prescribe it. You must pay the non-formulary copay.</li> </ul>	

*Covered medications and supplies continued on next page.*

Covered medications and supplies <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Vitamins, and minerals (both OTC and legend), except legend prenatal vitamins and liquid or chewable legend pediatric vitamins.</i></li> <li>• <i>Supplies such as dressings and antiseptics</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Drugs to aid in smoking cessation</i></li> <li>• <i>Drugs used for the primary purpose of treating infertility, including those given in connection with artificial insemination</i></li> <li>• <i>Oral dental preparations and fluoride rinses</i></li> <li>• <i>Drug therapy for weight loss (e.g. Xenical)</i></li> <li>• <i>Nonprescription medicines</i></li> <li>• <i>Drugs obtained at non-par pharmacies except for out of area emergency</i></li> </ul>	<p><i>All Charges</i></p>

**Section 5 (g). Special Features**

Feature	Description
<p><b>Member Services TDD for deaf and hearing impaired</b></p>	<p>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</p>
<p><b>Complex Case Management</b></p>	<p>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.</p>
<p><b>High risk pregnancies</b></p>	<p>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 800-735-4404 in Western PA and 800-788-8445 in Eastern PA.</p>
<p><b>Centers of excellence for transplants/heart surgery/etc</b></p>	<p>HealthAmerica has a nationally recognized organ transplant network (referred to as 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 of, these Centers of Excellence call Member Services. Care provided outside the Centers of Excellence network will not be covered.</p>

## Section 5 (h). Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your Costs for Covered Services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Accidental injury benefit	You pay
<p>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. Covered services must be rendered within 24 hours of the accident.</p> <p>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.</p>	<p>Nothing</p>
<p><u>Not covered:</u></p> <ul style="list-style-type: none"> <li>• <i>Services provided after the initial 24 hours post</i></li> <li>• <i>Orthodontia and all other dental related services</i></li> <li>• <i>Services provided by non-participating dentists</i></li> </ul> <p><i>Other dental services shown as not covered.</i></p>	<p><i>All charges</i></p>

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

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

### **HealthAmerica Dental Plan –**

HealthAmerica has partnered with Dominion Dental Services, Inc. to provide HealthAmerica Federal Government members with discounted dental services. You Pay a \$10 office visit copay for cleanings and exams and you receive discounts on other dental procedures. To receive these benefits you must use a participating dentist.

This dental benefit is an optional dental benefit and is available at no additional premium when you choose HealthAmerica's HMO medical option. To apply for federal HealthAmerica dental coverage, you must be enrolled in the HealthAmerica HMO medical option and you must complete a dental enrollment form.

If you have any questions or need additional information simply call Dominion Dental Services at (888)-518-5338. Or you can access their web site at [www.DominionDental.com/ha](http://www.DominionDental.com/ha).

### **Other Benefits and Services:**

**Vision Coverage** - All HealthAmerica members automatically qualify for a "20/20" vision benefit, which provides a 20% discount off the normal retail price for lenses, frames and contact lenses at Plan participating vision providers.

**Health Education Classes** - Classes include Weight Management, Diabetic Education, Prenatal Education, Stress Management and Smoking Cessation.

**Health Club Discounts** - HealthAmerica members are eligible for discounted initiation fees and discounted monthly membership fees at Plan participating health clubs.

**American Specialties Health Network (ASHN)**- A discount program offering complimentary and alternative care for members to broaden their health care options. Some services include massage therapy, acupuncture, nutritional supplements and vitamins and discounts on health club memberships.

To obtain an approved listing of programs available or request a provider directory or call our customer service department at 800/735-4404 for the Greater Pittsburgh region or 800/788-8445 in South Central, Central and Northeast Pennsylvania. Or you can receive additional information regarding any of our programs by accessing the HealthAmerica web site at [www.healthamerica.cvtv.com](http://www.healthamerica.cvtv.com).

BENEFITS ON THIS PAGE ARE NOT PART OF THE FEHB CONTRACT

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

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

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

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## Section 7. Filing a claim for covered services

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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 HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-735-4404 for the greater Pittsburgh region or 1-800-788-8445 in South Central, Central and Northeast Pennsylvania.

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

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

**Submit your claims to:** **Harrisburg** HealthAmerica  
Attn: Member Services Department  
2575 Interstate Drive  
Harrisburg PA 17110-9339

**Pittsburgh**-HealthAmerica  
Attn: Member Services Department  
Cranberry Business Park  
120 East Kensinger  
Cranberry Township PA 16066

### Prescription drugs

**Submit your claims to: Must complete a claim reimbursement form.**  
Contact the plan in the Harrisburg Area at (717)-540-4260 or 800-788-8445 or in the Pittsburgh Area at (412)-553-7300 or 800-735-4404.

### 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.

### When we need more information

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

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## Section 8. The disputed claims process

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

Step	Description
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| <b>1</b> | Ask us in writing to reconsider our initial decision. You must: <ol style="list-style-type: none"><li>Write to us within 6 months from the date of our decision; and</li><li>Send your request to us at: <b>South Central, Central, Northeast Region;</b> HealthAmerica, Attn: Member Services Department, 2575 Interstate Drive, Harrisburg PA 17110-9339 or <b>Greater Pittsburgh Region-</b> HealthAmerica, Attn: Member Services Department, Cranberry Business Park, 120 East Kensinger, Cranberry Township PA 16066 and</li><li>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ol> |
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| <b>2</b> | We have 30 days from the date we receive your request to: <ol style="list-style-type: none"><li>Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>Write to you and maintain our denial – go to step 4; or</li><li>Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.</li></ol> |
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| <b>3</b> | 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. |
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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.

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| <b>4</b> | If you do not agree with our decision, you may ask OPM to review it. |
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You must write to OPM within:

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

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division, P.O. Box 436, Washington, D.C. 20044-0436.

## **The Disputed Claims process (*Continued*)**

Send OPM the following information:

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

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

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

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

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

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

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

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

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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800/735-4404 for the Greater Pittsburgh region; or 800/788-8445 in South Central, Central and Northeast Pennsylvania. and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You can call OPM's Health Benefits Contracts Division xx at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

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## Section 9. Coordinating benefits with other coverage

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

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

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

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

### • What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

### • The Original Medicare Plan

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

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. 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. Under your FEHB coverage, we do not waive any of the copayments.

**(Primary payer chart begins on next page.)**

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

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

**Claims process** – You should not have to file a claim form when you have both our Plan and Medicare as long as you use our providers. In some cases, you may need to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. It is possible that you will have to provide us with the Explanation of Medicare Benefits. To find out if you need to do something about filing your claims, call us at 1-800-735-4404 in the Greater Pittsburgh region or at 1-800-788-8445 in South Central, Central and Northeast Pennsylvania.

**We do not waive your FEHB copays or coinsurance when you have Medicare.**

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

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

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

- **Enrollment in Medicare Part B**

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

## **TRICARE**

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

## **Workers' Compensation**

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers

## **Medicaid**

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

## **When other Government agencies are responsible for your care**

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

## **When others are responsible for injuries**

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, 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.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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

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<b>Calendar year</b>	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.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 10.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. See page 10.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	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.
<b>Deductible</b>	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 10.
<b>Experimental or Investigational</b>	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 HealthAmerica's Member Services Department.
<b>Group Health Coverage</b>	Group Health Coverage is protection that provides payment of benefits for covered sickness or injury.
<b>Medical Necessity</b>	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.
<b>Primary Care Physician</b>	Primary Care Physician (PCP) is a family practitioner, internist or a pediatrician. Your PCP provides all routine care and will manage your preventive care, hospital care, and referrals to Specialists.
<b>Specialist Care Physician-</b>	A medical doctor other than your primary care physician (PCP) whose education and work experience focus on a particular area of medicine. For example, a cardiologist sees patients with heart disease and a neurologist deals with disorders that affect our central nervous system.
<b>Us/We</b>	Us and we refer to HealthAmerica
<b>You</b>	You refers to the enrollee and each covered family member.

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## Section 11. FEHB facts

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### No pre-existing condition limitation

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

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

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

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

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

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

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

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

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

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

## **When benefits and premiums start**

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

## **Your medical and claims records are confidential**

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

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

## **When you retire**

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

## **When you lose benefits**

### **• When FEHB coverage ends**

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

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

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

### **• Spouse equity coverage**

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

### **• TCC**

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

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

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

- **Converting to individual coverage**

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

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

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

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

## **Getting a Certificate of Group Health Plan Coverage**

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

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

## **Inspector General Advisory**

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800-735-4404 in the Greater Pittsburgh region or at 1-800-788-8445 in South Central, Central and Northeast Pennsylvania and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

## **Penalties for Fraud**

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

## **TCC eligibility**

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a “member of family” under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

## **Other features**

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

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

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## Summary of benefits for the HealthAmerica Pennsylvania, Inc. – 2001

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office .....	Office visit copay: \$10 primary care; \$15 specialist	12
Services provided by a hospital: • Inpatient.....	Nothing	24
• Outpatient .....	Nothing	25
Emergency benefits: • In-area .....	\$35 per urgent care center or emergency room visit	27
• Out-of-area .....	\$35 per urgent care center or emergency room visit	27
Mental health and substance abuse treatment.....	Regular cost sharing	29
Prescription drugs: Up to a 31-day supply from a Plan Retail Pharmacy.....	\$8 Formulary Generic, \$14 Name Brand, \$35 Non-Formulary per prescription unit or refill	32
Up to a 90-day supply from Plan Mail Order Pharmacy .....	\$16 Generic Formulary \$28 Name Brand Formulary, \$70 Non-Formulary per prescription unit or refill	
Dental Care: Accidental injury benefit only .....	Nothing	36
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## 2001 Rate Information for HealthAmerica Pennsylvania

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

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

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

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

### Greater Pittsburgh

Self Only	261	\$69.71	\$23.23	\$151.03	\$50.34	\$82.48	\$10.46
Self and Family	262	\$181.25	\$60.41	\$392.70	\$130.90	\$214.47	\$27.19

### Central, South Central, and Northeast Pennsylvania

Self Only	SW1	\$74.45	\$24.82	\$161.32	\$53.77	\$88.10	\$11.17
Self and Family	SW2	\$193.56	\$64.52	\$419.38	\$139.79	\$229.05	\$29.03