

Health Alliance Plan

<http://www.hap.org>

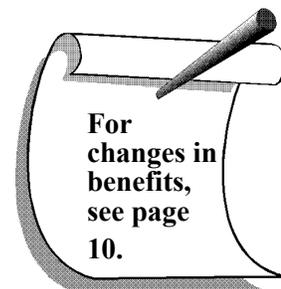


2008

A Health Maintenance Organization and a high deductible health plan

Serving: Detroit and Southeastern Michigan

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 10 for requirements.



This Plan has Excellent accreditation from NCQA. See the 2008 Guide for more information on NCQA.

Enrollment codes for this Plan:

521 Self Only

522 Self and Family

524 High Deductible Health Plan (HDHP) - Self Only

525 High Deductible Health Plan (HDHP) - Self and Family



Authorized for distribution by the:



United States
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Center for
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<http://www.opm.gov/insure>

RI 73-015

**Important Notice from HAP About
Our Prescription Drug Coverage and Medicare**

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may also have to wait until the next Annual Coordinated Delection Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction	4
Plain Language.....	4
Stop Health Care Fraud!	4
Preventing medical mistakes.....	5
Section 1 Facts about this HMO plan	8
General features of our High Option Plan	9
How we pay providers	0
General features of our High Deductible Health Plan	9
Preventive care services.....	9
Annual deductible	9
Health Savings Account (HSA).....	9
Health Reimbursement Arrangement (HRA).....	10
Catastrophic protection	10
Health education resources and accounts management tools	10
Your Rights	0
Your medical and claims records are confidential	10
Service Area	0
Section 2 How we change for 2008	10
Changes to our HMO Plan	11
Changes to our High Deductible Health Plan	11
Section 3. How you get care	11
Identification cards.....	11
Where you get covered care.....	11
• Plan providers.....	0
• Plan facilities	0
What you must do to get covered care	11
• Primary care.....	0
• Specialty care.....	0
• Hospital care	0
If you are hospitalized when your enrollment begins	12
Circumstances beyond our control.....	12
Services requiring our prior approval	13
Section 4 Your costs for covered services.....	14
Co-payments	14
Cost-sharing	15
Deductible	14
Coinsurance.....	14
Your catastrophic protection out-of-pocket maximum	14
Carryover	15
When Government facilities bill us	15
Section 5 High Option Benefits	16
High Deductible Health Plan Benefits.....	42
• Preventive care	44
• Traditional medical coverage.....	44
• Savings.....	44
• Health Savings Account (HSA).....	45

• Health Reimbursement Arrangements (HRA).....	46
• Catastrophic protection for out-of-pocket expenses.....	46
• Health education resources and accounts management tools.....	46
• Self Only enrollment	47
• Self and Family enrollment	47
• Self Only enrollment	48
• Self and Family enrollment	49
• Medical	49
• Non-medical	49
Non-FEHB benefits available to Plan members	79
Section 6 General exclusions – things we don’t cover	80
Section 7 Filing a claim for covered services	81
Medical and hospital benefits	81
Prescription drugs	81
Other supplies or services	81
Deadline for filing your claim.....	81
When we need more information.....	81
Section 8 The disputed claims process.....	82
Section 9 Coordinating benefits with other coverage	84
When you have other health coverage	84
What is Medicare?	84
• Should I enroll in Medicare?	84
• The Original Medicare Plan (Part A or Part B).....	85
• Medicare Advantage (Part C)	85
• Medicare prescription drug coverage (Part D)	86
TRICARE and CHAMPVA	88
Workers’ Compensation	88
Medicaid.....	88
When other Government agencies are responsible for your care	88
When others are responsible for injuries.....	88
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage	87
Section 10 Definitions of terms we use in this brochure	89
Section 11 FEHB Facts	91
Coverage information	90
No pre-existing condition limitation.....	91
Where you can get information about enrolling in the FEHB Program	91
Types of coverage available for you and your family.....	91
Children’s Equity Act.....	91
When benefits and premiums start.....	92
When you retire.....	92
When you lose benefits.....	90
When FEHB coverage ends	92
Upon divorce.....	93
Temporary Continuation of Coverage (TCC).....	93
Converting to individual coverage.....	93
Getting a Certificate of Group Health Plan Coverage	93
Section 12 Three Federal Programs complement FEHB benefits	94
Important Information.....	93

The Federal Flexible Spending Account Program – FSAFEDS	93
• What is an FSA?	93
• Where can I get more information about FSAFEDS?	93
The Federal Long Term Care Insurance Program - FLTCIP	93
• It's important protection	93
The Federal Employees Dental and Vision Insurance Program - FEDVIP	94
• Important Information	94
• Dental Insurance	94
• Vision Insurance	94
• Additional Information	94
• How do I enroll?	94
Index	-1
Summary of benefits for the HMO Plan Health Alliance Plan - 2008.....	99
2008 Rate Information for Health Alliance Plan	101

Introduction

This brochure describes the benefits of Health Alliance Plan under our contract (CS 1092) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Health Alliance Plan administrative offices is:

Health Alliance Plan

2850 West Grand Boulevard

Detroit, Michigan 48202

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have the right to benefits that were available before January 1, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 800/556-9765 and explain the situation.

If we do not resolve the issue:

CALL ¼ THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

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

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

3. **Get the results of any test or procedure.**

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

Exactly what will you be doing?

About how long will it take?

What will happen after surgery?

How can I expect to feel during recovery?

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety:

Ø www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you a choice of enrollment in a High Option HMO or a High Deductible Health Plan (HDHP). 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 pay only the copayments, co-insurance, 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. **General features of our High Option Plan** Our High Option plan is a traditional HMO. Generally, you pay copayments or co-insurance for office visits and most other services. There are no deductibles or out-of-pocket maximum limits. **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 co-insurance. **General features of our High Deductible Health Plan (HDHP)** HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements that can be used to pay for medical expenses such as deductibles and copayments. Funds are easily accessed through the use of a debit card. Please see below for more information about these savings features. • **Preventive care services** Preventive care services are paid as first dollar coverage though a copayment for the office visit will apply. First dollar coverage is not limited to a maximum dollar amount each year. • **Annual deductible** The annual deductible must be met before Plan benefits are paid for care other than preventive care services. • **Health Savings Account (HSA)** You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, and are not claimed as a dependent on someone else's tax return. • You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense. • Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP. • You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn. • For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest. • You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan. • **Health Reimbursement Arrangement (HRA)** If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences. • An HRA does not earn interest. • An HRA is not portable if you leave the Federal government or switch to another plan. • **Catastrophic protection** We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$5,000 for Self Only enrollment, or \$10,000 family coverage. • **Health education resources and accounts management tools** There are two components to HDHP education. First, are resources on health education, found at www.hap.org such as: iStrive for better health, HAP's HealthTrack, Health Tools, Subimo and Member Health Manager, these tools help educate members on making health care decisions. Second, if you enroll in either the HSA or HRA, you will be provided with both online education and account management tools. Included in these online tools are an overview of either your HRA or HSA fund, frequently asked questions, decision-support tools and online account balances and a detailed transaction history. In addition, you will receive a welcome kit that outlines the basics of your account and how to get started. **Your rights** OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below. • The Plan is federally qualified and licensed by the State of Michigan as an HMO. • The Plan has been licensed as an HMO since 1979. • The Plan is a Michigan non-profit corporation If you want more information about us, call 313/664-8757 or 800/556-9765 or write to HAP at 2850 West Grand Boulevard, Detroit, MI 48202. You may also visit our website at www.hap.org. **Your medical and claims records are confidential** We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies. **Service Area** To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is Genesee, Lapeer, Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne Counties. Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval. If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a

Section 2 How we change for 2008

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

Changes to our HMO Plan

- Your share of the non-Postal premium will decrease for Self Only or decrease for Self and Family. See page 97.
- Your office visit copay when seeking care from a specialist, including mental health and chemical dependency services, will increase from \$10 to \$20 per visit.
- Your copay when seeking care at an urgent care facility will increase from \$10 to \$25 per visit.
- Your copay when seeking emergency care as an outpatient at a hospital will increase from \$50 to \$75 per visit.
- Your copay for inpatient hospital care will increase from \$0 to \$250 per admission.
- Your copay for (retail) branded prescription drugs will increase from \$20 to \$40 per prescription for a 30-day supply. Your copay for mail order branded prescription drugs will increase from \$55 to \$80 for a 90-day supply.
- Your copay for durable medical equipment, prosthetic appliances and orthotics will increase from \$0 to 50% per authorized item.

Changes to our High Deductible Health Plan

- This Plan is new to the FEHB Program. Our HDHP is being offered for the first time during the 2007 Open Season

Section 3. How you get care

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 313/664-8757 or 800/556-9765 or write to us at HAP, 2850 West Grand Boulevard, Detroit, MI 48202. You may also request replacement cards through our website at www.hap.org.

Where you get covered care You get care from “Plan providers” and “Plan facilities.” You will only pay co-payments 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, National Committee on Quality Assurance standards and other applicable regulatory bodies.

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

- **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 Web site.

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

We offer the flexibility of selecting a PCP based on your needs. You may want to select a PCP located near your work, while a physician close to school or home is better for your children. Physician profiles are available through the Client Services Department’s computerized system called “PCPSelect.” When you call Client Services, a PCP Selection Assistant will assist you with finding a PCP based on your personal preferences. Simply call our toll-free PCPSelect line at: 888/PIC-A-PCP or 888/742-2727. You may also select a PCP using our on-line PCPSelect services. Visit HAP’s website at www.hap.org and choose “PCPSelect On-Line.”

- **Primary care** Your primary care physician can be a family practitioner, internist, general practitioner, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care** Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see an obstetrician-gynecologist for an annual office visit and routine ob-gyn care without a referral.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with a specialist to 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 and 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 program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan.

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

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

• **Hospital care**

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

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 313/664-8757 or 800/556-9765. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

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

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case², the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process pre-certification. Your physician must obtain pre-certification for the following services:

- Select outpatient procedures
- Diagnostic tests
- Home care services
- Durable medical equipment
- Inpatient care
- Mental Health and Substance Abuse (MH/SA)
- Non-emergency ambulance services

Failure to obtain pre-certification may result in financial liability on behalf of the member or the provider.

Physicians may contact us by phone, fax or electronically to submit new requests or to seek a renewal or extension of an existing referral.

Section 4 Your costs for covered services

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

Co-payments

A co-payment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: Under the High Option plan, when you see your primary care physician you pay a co-payment of \$10 per office visit and when you go in the hospital, you pay \$250 per admission.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., copayments) for the covered care you receive.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- There is no deductible for the High Option plan.

- For the High Deductible Health Plan, the calendar year deductible is \$1,500 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$3,000.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: In our High Option Plan, you pay 50% of the cost for durable medical equipment and prosthetic appliances.

Your catastrophic protection out-of-pocket maximum

Your out-of-pocket expenses for benefits under the High Option Plan are limited to the stated copayments required for a few benefits.

In our HDHP option, after your out-of-pocket expenses total \$5,000 per person or \$10,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

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

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government facilities bill us

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

Section 5 High Option Benefits

See page **11** for how our benefits changed this year. Page **95** is a benefits summary of this option. Make sure that you review the benefits that are available.

Section 5 High Option Benefits16

Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....18

 Diagnostic and treatment services.....18

 Lab, X-ray and other diagnostic tests.....18

 Preventive care, adult.....18

 Preventive care, children.....19

 Maternity care19

 Family planning20

 Infertility services20

 Allergy care.....21

 Treatment therapies.....21

 Physical and occupational therapies21

 Speech therapy22

 Hearing services (testing, treatment, and supplies).....22

 Vision services (testing, treatment, and supplies).....22

 Foot care.....23

 Orthopedic and prosthetic devices23

 Durable medical equipment (DME).....24

 Home health services24

 Chiropractic.....24

 Alternative treatments25

 Educational classes and programs.....25

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals26

 Surgical procedures.....26

 Reconstructive surgery.....27

 Oral and maxillofacial surgery.....27

 Organ/tissue transplants28

 Anesthesia29

Section 5(c) Services provided by a hospital or other facility, and ambulance services30

 Inpatient hospital.....30

 Outpatient hospital or ambulatory surgical center31

 Extended care benefits/Skilled nursing care facility benefits31

 Hospice care.....32

 Ambulance32

Section 5(d) Emergency services/accidents33

 Emergency within our service area34

 Emergencyoutside our service area.....34

 Ambulance34

Section 5(e) Mental health and substance abuse benefits35

 Mental health and substance abuse benefits35

Section 5(f) Prescription drug benefits36

 Covered medications and supplies.....37

Section 5(h) Special features.....39

Section 5(g) Dental benefits.....38

Summary of benefits for the HMO Plan Health Alliance Plan - 2008.....99

This Plan offers a High Option HMO. The benefit package is described in Section 5. Make sure that you review the benefits that are available.

Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High Option benefits, contact us at 313/664-8757 or 800/556-9765 or at our Web site at www.hap.org.

You must use plan providers for your care, except for emergency and urgently needed services.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	High Option
Professional services of physicians <ul style="list-style-type: none"> • In physician's office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultation • Second surgical opinion 	\$10 per visit to your primary care physician \$20 per visit to a specialist
At home	Nothing
Lab, X-ray and other diagnostic tests	High Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing if you receive these services during your office visit; otherwise: \$10 per visit to your primary care physician \$20 per visit to a specialist
Preventive care, adult	High Option
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	Nothing if you receive these services during your office visit; otherwise: \$10 per visit to your primary care physician \$20 per visit to a specialist

Benefit Description	You pay
Preventive care, adult (cont.)	High Option
<p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p> <p>Routine pap test</p> <p>Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i>, above.</p> <p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years <p>Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	<p>Nothing if you receive these services during your office visit; otherwise:</p> <p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<p><i>All charges</i></p>
Preventive care, children	High Option
<p>Childhood immunizations recommended by the American Academy of Pediatrics</p> <p>Well-child care charges for routine examinations, immunizations and care (up to age 22)</p> <p>Examinations, such as:</p> <ul style="list-style-type: none"> • Eye exams to determine the need for vision correction • Ear exams to determine the need for hearing correction • Examinations done on the day of immunizations 	<p>Nothing if you receive these services during your office visit; otherwise:</p> <p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>
Maternity care	High Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p>	<p>\$20 per office visit</p>

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	High Option
<ul style="list-style-type: none"> • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. <p>We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</p>	\$20 per office visit
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges.</i>
Family planning	High Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<i>All charges</i>
Infertility services	High Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits; oral and self-injectable fertility drugs under the prescription drug benefit.</p>	<p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>
<i>Not covered:</i>	<i>All charges</i>

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	High Option
<ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges</i>
Allergy care	High Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>
Allergy serum	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>
Treatment therapies	High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. Your physician will obtain authorization for you.</p>	<p>Nothing if you receive these services during your office visit; otherwise:</p> <p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>
Physical and occupational therapies	High Option
<p>60 visits per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 sessions. 	<p>\$10 per office visit</p> <p>\$10 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission (inpatient copay may apply)</p>

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<p><i>All charges</i></p>
Speech therapy	
<p>60 visits per condition</p>	<p>High Option</p> <p>\$10 per office visit</p> <p>\$10 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p>
Hearing services (testing, treatment, and supplies)	
<p>Hearing testing for all members</p>	<p>High Option</p> <p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Hearing aid fittings • Hearing aids, testing and examinations for them 	<p><i>All charges</i></p>
Vision services (testing, treatment, and supplies)	
<p>Eye exam to determine the need for vision correction</p>	<p>High Option</p> <p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>
<p>One pair of eyeglasses or contact lenses to correct an impairment directly caused by intraocular surgery (such as cataracts)</p> <ul style="list-style-type: none"> • Plan guidelines cover an allowance of \$40 for eyeglass frames. Lenses are limited to glass or plastic, ground or molded with a quality equal to the first quality lens series manufactured by American Optical, Bausch and Lomb, or Univis; and which meet the Z80.1 or Z80.2 standards of the American National Standards Institute, including equivalent plastic or tints equal to pink tints #1 and #2. Lenses may not exceed 65 millimeters in diameter. • Plan guidelines cover an allowance of \$80 for contact lenses for members who voluntarily choose contact lenses over eyeglasses. • Plan guidelines provide no coverage for extra charges including, but not limited to, photosensitive or antireflective lenses, polycarbonate, progressive and transitional lenses, scratch guard, UV protection, tints beyond pink tint #1 and #2. 	<p>Charges over the plan guidelines</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eyeglasses or contact lenses • Eye exercises and orthoptics 	<p><i>All charges</i></p>

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

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	High Option
<ul style="list-style-type: none"> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>
Foot care	High Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <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> 	<i>All charges</i>
Orthopedic and prosthetic devices	High Option
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. 	50% co-insurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> 	<i>All charges</i>

Benefit Description	You pay
Durable medical equipment (DME)	High Option
<p>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:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. 	50% co-insurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Foot orthotics</i> • <i>Physician Equipment</i> • <i>Medical equipment needed only for comfort and convenience</i> • <i>Replacement or repair of any medical equipment or prosthetic or orthopedic device due to misuse, whether intentional or unintentional</i> • <i>Eyeglasses or contact lenses including fitting of contact lenses except as necessary for the first pair of corrective lenses following cataract surgery</i> 	<i>All charges</i>
Home health services	High Option
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges</i>
Chiropractic	High Option
No benefit	<i>All charges</i>

Benefit Description	You pay
Alternative treatments	High Option
No benefit	<i>All charges</i>
Educational classes and programs	High Option
Coverage is limited to: <ul style="list-style-type: none"> • Smoking Cessation • Diabetes self management Other programs may be available. Contact Plan for details.	\$10 per visit to your primary care physician \$20 per visit to a specialist

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

Important things you should keep in mind about these benefits:•Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. •Plan physicians must provide or arrange your care. •Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. •The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). •**YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery) – eligible members must meet the following criteria: <ul style="list-style-type: none"> - Weight 100 pounds or 100% over normal weight according to current underwriting standards; - Body mass index greater than 35 and at least 2 life-threatening co-morbid conditions, or BMI greater than 40 without co-morbid conditions; - Psychological evaluation demonstrating emotional stability and ability to comply with post-surgical limitations; - Documented compliance with a medically-supervised weight loss program including diet, exercise and behavior modification for at least 1 year; and - Medical evaluation rules out other treatable causes of morbid obesity. 	<p>\$250 per inpatient admission</p> <p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	High Option
<ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information 	\$250 per inpatient admission \$10 per visit to your primary care physician \$20 per visit to a specialist
Reconstructive surgery	High Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> • the condition produced a major effect on the member’s appearance and • the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <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>	\$250 per inpatient admission \$10 per visit to your primary care physician \$20 per visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	High Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and 	\$250 per inpatient admission \$10 per visit to your primary care physician \$20 per visit to a specialist

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	High Option
<ul style="list-style-type: none"> • Other surgical procedures that do not involve the teeth or their supporting structures. • Treatment for temporomandibular joint (TMJ) disorders (non-dental) 	<p>\$250 per inpatient admission</p> <p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	High Option
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure.</p> <p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Intestinal transplants • Allogeneic bone marrow transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>Nothing, but the inpatient hospital copayment may apply</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for 	<p>Nothing, but the inpatient hospital copayment may apply</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer). 	Nothing, but the inpatient hospital copayment may apply
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrick syndrome) • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer <p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <ul style="list-style-type: none"> • National Transplant Program (NTP) <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing, but the inpatient hospital copayment may apply
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>
Anesthesia	High Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Nothing, but the inpatient hospital copayment may apply.</p> <p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	High Option
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$250 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	\$250 per admission
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> 	<i>All charges</i>

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	High Option
<ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	High Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <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 procedures.</p>	Nothing
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits	High Option
<p>Extended care benefit:</p> <p>The Plan provides a comprehensive range of benefits when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor. The Plan pays for up to 730 days each continuous period of confinement or for successive periods separated by less than 60 days. This 730-day period will be reduced by two days for every inpatient hospital day prior to or during an admission to a skilled nursing facility. A new period of 730 days will begin after at least 60 days have elapsed from the last date of discharge. You pay nothing. All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor. 	Nothing
<i>Not covered: custodial care</i>	<i>All charges</i>

Benefit Description	You pay
Hospice care	High Option
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; those services which are provided under the direction of a Plan doctor who certified that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. This benefit is limited to 210 days per member per lifetime.</p>	Nothing
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<i>All charges</i>
Ambulance	High Option
<p>Local professional ambulance service when medically appropriate</p>	Nothing

Section 5(d) Emergency services/accidents

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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your Plan physician. In extreme emergencies, if you are unable to contact a doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan.

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

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

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

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

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

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

Benefit Description	You pay
Emergency within our service area	High Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctor’s services <p>Note: We waive the ER copay if you are admitted to the hospital</p>	<p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p> <p>\$25 per visit to an urgent care center</p> <p>\$75 per visit to an ER department</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	High Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctor’s services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$10 per visit to your primary care physician</p> <p>\$20 per visit to a specialist</p> <p>\$25 per visit to an urgent care center</p> <p>\$75 per visit to an ER department</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges.</i>
Ambulance	High Option
<p>Professional ambulance service (including air ambulance) when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	Nothing

Section 5(e) Mental health and substance abuse benefits

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.

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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION OF THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	High Option
<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 illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$20 per visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing if you receive these services during your office visit, otherwise, \$20 per office visit</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment. 	<p>\$250 per admission</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>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.</i></p>	<p><i>All charges</i></p>

Preauthorization	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:</p> <ul style="list-style-type: none"> • You may directly access services by contacting Coordinated Behavioral Health Management at 800/444-5755
Limitation	<p>We may limit your benefits if you do not obtain a treatment plan.</p>

Section 5(f) Prescription drug benefits

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.
- 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.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **We use a formulary.** A Plan formulary is a list of Plan-approved prescription drugs. We cover non-formulary drugs prescribed by a Plan doctor.

We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call Client Services at 313/664-8757 or 800/556-9765.

- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply; you pay a \$10 copay per prescription unit or refill for generic drugs, you pay a \$40 copay per prescription unit or refill for brand name drugs when no generic substitute is available or your physician specifically requires the brand name drug. Generic maintenance drugs (those listed on HAP's Maintenance Drug List) are covered up to a 30-day supply for the \$10 copay per prescription unit or refill. The cost of prescriptions filled at non-Plan pharmacies is reimbursable to the enrollee only for out-of-service emergencies, minus the appropriate copay per prescription or refill.

Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications, should call our Client Services Department at 313/664-8757 or 800/556-9765.

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

- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than a name-brand drug.
- **When you do have to file a claim.** See Section 7 for information of filing a claim for the prescription drug benefits.

Benefit Description	You pay
<p>Covered medications and supplies</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"> • Oral contraceptive drugs • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as Not covered. • Insulin • Compounded dermatological preparations • Implanted time-release medications, such as Norplant. For Norplant, you pay a \$10 office visit copay per prescription. For other internally implanted time-release medications, you pay a \$10 office visit copay. There is no charge when the device is implanted during a covered hospitalization. • Disposable needles and syringes needed to inject covered prescribed medication • Intravenous fluids and medication for home use are covered under Medical and Surgical Benefits • Injectable medications <p>Limited as to number of month’s supply:</p> <ul style="list-style-type: none"> • Smoking cessation drugs and medications including nicotine patches (up to a three-month supply per year) • Drugs for sexual dysfunction (such as Viagra) limited to 4 tablets every 28 days • Injectable infertility drugs • Growth Hormone 	<p>High Option</p> <p><u>Plan (retail) Pharmacy:</u></p> <ul style="list-style-type: none"> • \$10 per prescription unit or refill for a 30-day supply of generic drugs; • \$40 per prescription unit or refill for a 30-day supply of brand name drugs (a generic equivalent will be dispensed if it is available, unless the physician specifically requires a name brand. Brand name drugs with a generic equivalent are only covered when the physician writes “Dispense as Written (DAW) on the prescription). <p><u>Mail Order</u> (See section 5 (i) for information about our mail order program):</p> <ul style="list-style-type: none"> • \$20 per prescription unit or refill for up to a 90-day supply of generic drugs; • \$80 per prescription unit or refill for up to a 90-day supply of brand name drugs (if no generic substitute is available or the physician specifically requires the brand name drug). <p>NOTE: If you request a brand name drug and a generic substitute is available, you must pay the generic copay plus the difference in cost between the generic and the brand name drug.</p> <p>If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available.</i> 	<p><i>All charges</i></p>

Section 5(g) Dental benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

Dental Benefits	
Service	High Option
<i>We have no other dental benefits.</i>	<i>All charges.</i>

Section 5(h) Special features

Feature	Description
Flexible benefits option	High Option
<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.

High Deductible Health Plan Benefits

	See page 96 for a benefit summary	
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Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	18
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals	26
Section 5(c) Services provided by a hospital or other facility, and ambulance services	30
Section 5(d) Emergency services/accidents	33
Section 5(e) Mental health and substance abuse benefits	35
Section 5(f) Prescription drug benefits	36
Section 5(g) Dental benefits.....	38
Section 5(h) Special features.....	39

Section 5 High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at **313/664-8757 or 800/556-9765** or at our Web site at www.hap.org.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With this Plan, preventive care **is covered in full (not subject to deductible, but subject to copays)**. As you receive other non-preventive medical care, you must meet the Plan’s deductible before we pay benefits according to the benefits described on pages 53 to 75. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care** The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations. **These services are covered at 100% if you use a Plan provider and the services are described in Section 5 Preventive care. You do not have to meet the deductible before using these services. This does not reduce your HSA or HRA.**

- **Traditional medical coverage** After you have paid the Plan’s deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays **100%** for in-network care **however, copays may apply.**

Covered services include:

 - Medical services and supplies provided by physicians and other health care professionals
 - Surgical and anesthesia services provided by physicians and other health care professionals
 - Hospital services; other facility or ambulance services
 - Emergency services/accidents
 - Mental health and substance abuse benefits
 - Prescription drug benefits

- **Savings** Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 49 for more details).

• **Health Savings Accounts (HSA)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else’s tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2008, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA **\$62.50** per month for a Self Only enrollment or **\$125** per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$2,900 for an individual and \$5,800 for a family. See maximum contribution information on page 48. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don’t deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your HSA is administered by **ACS/Mellon HSA Solution**
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It’s portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

• **Health Reimbursement Arrangements (HRA)**

If you are not eligible for an HSA, for example you are enrolled in Medicare or have another health plan; we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2008, we will give you an HRA credit of **\$750** per year for a Self Only enrollment and **\$1,500** per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don’t count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by **WageWorks**
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment

- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.

An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements. See *Who is eligible to enroll?* in Section 12 under The Federal Flexible Spending Account Program – *FSAFEDS*.

- **Catastrophic protection for out-of-pocket expenses**

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles and copayments) for covered services is limited to **\$5,000** per person or **\$10,000** per family enrollment. Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

- **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5 Savings - HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) - Provided when you are ineligible for an HSA
Administrator	<p>The Plan will establish an HSA for you with ACS Mellon HSA Solution, this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)</p> <p>ACS Mellon HSA Solution, P.O. Box 1008, Totowa, NJ 07511-1008</p> <p>www.hsamember.com</p>	<p>Wage-Works is the HRA fiduciary for this Plan.</p> <p>WageWorks, Inc.</p> <p>1100 Park Place, 4th Floor</p> <p>San Mateo, CA 94403</p> <p>www.wageworks.com</p>
Fees	<p>Set-up fee is paid by the HDHP.</p> <p>The administrative fee is covered in the premium while the member is covered under the HDHP.</p> <p>Refer to the 2008 HSA Mellon Fee Schedule for optional/ad hoc services fees.</p>	<p>HRA administrative fees are included in the plan’s premium rates.</p>
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare 	<p>You must enroll in this HDHP.</p>

	<ul style="list-style-type: none"> • Not be claimed as a dependent on someone else’s tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork. 	<p>Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.</p>
<p>Funding</p>	<p>If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.</p> <p>In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).</p>	<p>Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.</p>
<ul style="list-style-type: none"> • Self Only enrollment 	<p>For 2008, a monthly premium pass through of \$62.50 will be made by the HDHP directly into your HSA each month.</p>	<p>For 2008, your HRA annual credit is \$750 (prorated for mid-year enrollment).</p>
<ul style="list-style-type: none"> • Self and Family enrollment 	<p>For 2008, a monthly premium pass through of \$125 will be made by the HDHP directly into your HSA each month.</p>	

		For 2008, your HRA annual credit is <i>\$1,500</i> (prorated for mid-year enrollment).
Contributions/credits	<p>he maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of \$2,900 for an individual and \$5,800 for a family.</p> <p>If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.</p> <p>You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.</p> <p>If you do not meet the 12-month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.</p> <p>You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP).</p> <p>HSAs earn tax-free interest (does not affect your annual maximum contribution).</p>	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.
• Self Only enrollment	You may make an annual maximum contribution of <i>\$2,150</i> .	You cannot contribute to the HRA.
• Self and Family enrollment	You may make an annual maximum contribution of <i>\$4,300</i> .	

		You cannot contribute to the HRA.
Access funds	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> • Debit card • Checks 	<p>For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.</p>
<p>Distributions/withdrawals</p> <ul style="list-style-type: none"> • Medical 	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p>

		<p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>
<ul style="list-style-type: none"> • Non-medical 	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.</p>	

	When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you. 	The entire amount of your H-RA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP
Portable	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 47 for HSA eligibility.</p>	If you retire and remain in this HD-HP, you may continue to use and accumulate credits in your H-RA.

		<p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
<p>Annual rollover</p>	<p>Yes, accumulates without a maximum cap.</p>	<p>Yes, accumulates without a maximum cap.</p>

If you have an HSA

- **Contributions**

All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

If you newly enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions** If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. In 2008, you may contribute up to \$900 in catch-up contributions. The allowable catch-up contribution will be \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.
- **If you die** If you do not have a named beneficiary, if you are married, it becomes your spouse’s HSA; otherwise, it becomes part of your taxable estate.
- **Qualified expenses** You can pay for “qualified medical expenses,” as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at www.irs.gov and click on “Forms and Publications.” Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses** You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- **Tracking your HSA balance** You will receive a periodic statement that shows the “premium pass through”, withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.
- **Minimum reimbursements from your HSA** You can request reimbursement in any amount. However, funds will not be disbursed until your reimbursement totals at least \$25

If you have an HRA

- **Why an HRA is established** If you don’t qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.
- **How an HRA differs** Please review the chart on page xx which details the differences between an HRA and an HSA. The major differences are:
 - You cannot make contributions to an HRA
 - Funds are forfeited if you leave the HDHP
 - An HRA does not earn interest, and
 - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include 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.

Section 5 Preventive Care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible. You only owe your copay for covered preventive care services.
- You must use providers that are part of our network.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*

Benefit Description	You Pay
Preventive care, adult	
Routine physicals every year which includes: Routine screenings, such as:	\$15 per visit to your primary care physician \$25 per visit to you specialist
<ul style="list-style-type: none"> • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 40 and older • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test yearly starting at age 50, - Sigmoidoscopy screening — every five years starting at age 50, - Double contrast barium enema — every five years starting at age 50; - Colonoscopy screening — every 10 years starting at age 50 • Routine mammogram — covered for women age 35 and older, as follows: <ul style="list-style-type: none"> - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years 	
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	\$15 per visit to your primary care physician \$25 per visit to your specialist
<ul style="list-style-type: none"> • Routine physicals which include: <ul style="list-style-type: none"> - One exam every 24 months up to age 65 - One exam every 12 months age 65 and older • Routine exams limited to: <ul style="list-style-type: none"> - 1 routine eye exam every 12 months - 1 routine OB/GYN exam every 12 months including 1 Pap smear and related services - 1 routine hearing exam every 24 months 	\$15 per visit to your primary care physician \$25 per visit to your specialist
<i>Not covered:</i>	<i>All charges</i>

Benefit Description	You Pay
Preventive care, adult (cont.)	
<ul style="list-style-type: none"> Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel. 	<i>All charges</i>
Preventive care, children	
<p>Professional services, such as:</p> <ul style="list-style-type: none"> Well-child visits for routine examinations, immunizations and care (up to age 22) Childhood immunizations recommended by the American Academy of Pediatrics Examinations, such as: <ul style="list-style-type: none"> Eye exam through age 17 to determine the need for vision correction Hearing exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) 	<p>\$15 per visit to your primary care physician</p> <p>\$25 per visit to your specialist</p>
<p><i>Notcovered:</i></p> <ul style="list-style-type: none"> <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> <i>Immunizations, boosters, and medications for travel.</i> 	<i>All charges</i>

Section 5 Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% (see page 44) and is not subject to the calendar year deductible. After the annual limit on in-network preventive care has been reached, additional preventive care is covered under Traditional medical coverage subject to the deductible.
- The deductible is **\$1,500** per person or **\$3,000** per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your copayments and deductibles total **\$5,000** per person or **\$10,000** per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers.
- In-network benefits apply only when you use a network provider.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the You pay column, we say “No deductible” when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$1,500 per person or \$3,000 per family enrollment
After you meet the deductible, we pay the allowable charge (less your copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the indicated copayments for covered services. You may choose to pay the copayments from your HSA or HRA, or you can pay for them out-of-pocket.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is **\$1,500** for Self Only enrollment and **\$3,000** for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay After the calendar year deductible...
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion 	\$15 per visit to your primary care physician \$25 per visit to your specialist
At home	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap test s • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	\$15 per visit to your primary care physician \$25 per visit to your specialist

Benefit Description	You Pay After the calendar year deductible...
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5c) and <i>Surgery benefits</i> (Section 5b). 	<p>\$25 per office visit</p> <p>\$250 copay per admission for labor & delivery</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges</i></p>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$25 per visit to your specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay After the calendar year deductible...
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$25 per visit to your specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg.</i> 	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$15 per visit to you primary care physician</p> <p>\$25 per visit to your specialist</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>sublingual allergy desensitization</i> 	<p><i>All charges</i></p>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 63.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$25 per visit to your specialist</p>

Treatment therapies - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Treatment therapies (cont.)	
<p>Note: – We only cover GHT when we preauthorize the treatment. Your doctor will obtain authorization for you.</p>	<p>\$15 per visit to your primary care physician \$25 per visit to your specialist</p>
Physical and occupational therapies	
<p>60 visits per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 sessions. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges</i></p>
Speech therapy	
<p>60 visits per condition</p>	<p>Nothing</p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Hearing testing for all members 	<p>\$15 per visit to your primary care physician \$25 per visit to your specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing tests</i> • <i>Hearing aids, testing and examinations for them</i> 	<p><i>All charges</i></p>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Eye exam to determine the need for vision correction • One pair of eyeglasses or contact lenses to correct an impairment directly caused by intraocular surgery (such as cataracts) • Plan guidelines cover an allowance of \$40 for eyeglass frames. Lenses are limited to glass or plastic, ground or molded with a quality equal to the first quality lens series manufactured by American Optical, Bausch and Lomb, or Univis; and which meet the Z80.1 or Z80.2 standards of the American National Standards Institute, including equivalent plastic or tints equal to pink tints #1 and #2. Lenses may not exceed 65 millimeters in diameter. 	<p>\$15 per visit to your primary care physician \$25 per visit to your specialist</p> <p>For eyeglass frames and contact lenses, all charges over the plan guidelines.</p>

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

Benefit Description	You Pay After the calendar year deductible...
Vision services (testing, treatment, and supplies) (cont.)	
<ul style="list-style-type: none"> Plan guidelines cover an allowance of \$80 for contact lenses for members who voluntarily choose contact lenses over eyeglasses. Plan guidelines provide no coverage for extra charges including, but not limited to, photosensitive or antireflective lenses, polycarbonate, progressive and transitional lenses, scratch guard, UV protection, tints beyond pink tint #1 and #2. <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	<p>\$15 per visit to your primary care physician \$25 per visit to your specialist</p> <p>For eyeglass frames and contact lenses, all charges over the plan guidelines.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Eyeglasses or contact lenses, except as shown above</i> <i>Eye exercises and orthoptics</i> <i>Radial keratotomy and other refractive surgery</i> 	<p><i>All charges</i></p>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>\$15 per visit to your primary care physician \$25 per visit to your specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> <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> 	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> Artificial limbs and eyes; stump hose Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. <p>Note: See 5(b) for coverage of the surgery to insert the device.</p>	<p>Covered for authorized equipment</p>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	
<ul style="list-style-type: none"> Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	Covered for authorized equipment
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Orthopedic and corrective shoes</i> <i>Arch supports</i> <i>Foot orthotics</i> <i>Heel pads and heel cups</i> <i>Lumbosacral supports</i> <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> 	<i>All charges</i>
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> Oxygen; Dialysis equipment; Hospital beds; Wheelchairs; Crutches; Walkers; Blood glucose monitors; and Insulin pumps. <p>Note: Call us at 313/664-8757 or 800/556-9765 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>	Covered for authorized equipment
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Foot orthotics</i> <i>Physician Equipment</i> <i>Medical equipment needed only for comfort and convenience</i> 	<i>All charges</i>

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	
<ul style="list-style-type: none"> • Replacement or repair of any medical equipment or prosthetic or orthopedic device due to misuse, whether intentional or unintentional • Eyeglasses or contact lenses including fitting of contact lenses except as necessary for the first pair of corrective lenses following cataract surgery. 	All charges
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient's family; • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. 	All charges
Chiropractic	
No benefit	All charges
Alternative treatments	
No benefit	All charges
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self management • Smoking cessation <p>Other programs may be available. Contact Plan for details.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$25 per visit to your specialist</p>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The deductible is **\$1,500** for Self Only enrollment and **\$3,000** for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You Pay After the calendar year deductible...
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) 	<p>\$15 per visit to your primary care physician</p> <p>\$25 per visit to your specialist</p> <p>\$250 copay per inpatient admission</p>
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery) – see page 27 for coverage criteria • Insertion of internal prosthetic devices . See 5(a) <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$25 per visit to your specialist</p> <p>\$250 copay per inpatient admission</p>

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Surgical procedures (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <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>	<p>\$15 per visit to your primary care physician</p> <p>\$25 per visit to your specialist</p> <p>\$250 copay per inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay After the calendar year deductible...
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$15 per visit to your primary care physician</p> <p>\$25 per visit to your specialist</p> <p>\$250 copay per inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure.</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Allogeneic bone marrow transplants • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>\$25 copay per inpatient admission</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma 	<p>\$250 copay per inpatient admission</p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Advanced non-Hodgkin’s lymphoma - Chronic myleognous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	\$250 copay per inpatient admission
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrick syndrome) • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer <p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <ul style="list-style-type: none"> • National Transplant Program (NTP) <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	\$250 copay per inpatient admission
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>

Benefit Description	You Pay After the calendar year deductible...
Anesthesia	
Professional services provided in – <ul style="list-style-type: none">• Hospital (inpatient)• Hospital outpatient department• Skilled nursing facility• Ambulatory surgical center• Office	Nothing

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions , limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary .
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The deductible is **\$1,500** for Self Only enrollment and **\$3,000** for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$250 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) 	\$250 per admission

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <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 procedures.</p>	<p>Nothing</p>
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges</i></p>
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care benefit:</p> <p>The Plan provides a comprehensive range of benefits when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor. The Plan pays for up to 730 days each continuous period of confinement or for successive periods separated by less than 60 days. This 730-day period will be reduced by two days for every inpatient hospital day prior to or during an admission to a skilled nursing facility. A new period of 730 days will begin after at least 60 days have elapsed from the last date of discharge. You pay nothing. All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care 	<p>Nothing</p>

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Extended care benefits/Skilled nursing care facility benefits (cont.)	
Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing
<i>Not covered: Custodial care</i>	<i>All charges</i>
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; those services which are provided under the direction of a Plan doctor who certified that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. This benefit is limited to 210 days per member per lifetime.	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>
Ambulance	
Local professional ambulance service when medically appropriate	Nothing

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is **\$1,500** for Self Only enrollment and **\$3,000** for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your copayments for eligible medical expenses and prescriptions.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your Plan physician. In extreme emergencies, if you are unable to contact a doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan.

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

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

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

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

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

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

Benefit Description	You Pay After the calendar year deductible
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$25 per visit to your specialist</p> <p>\$25 copay for urgent care</p> <p>\$75 copay per ER visit</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$25 per visit to your specialist</p> <p>\$25 copay for urgent care</p> <p>\$75 copay per ER visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	Nothing

Section 5(e) Mental health and substance abuse benefits

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.

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.
- The deductible is **\$1,500** for Self Only enrollment and **\$3,000** for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES. See the instructions after the benefits description below.

Benefits Description	You Pay After the calendar year deductible...
Mental health and substance abuse benefits	
<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 illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$25 per visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing if you receive these services during your office visit, otherwise, \$25 per visit</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$250 per admission</p>
<p><i>Not covered: Services we have not approved.</i></p>	<p><i>All charges</i></p>

Mental health and substance abuse benefits - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	
<i>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.</i>	<i>All charges</i>

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

You may directly access services by contacting Coordinated Behavioral Health Management at 800/444-5755

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

Section 5(f) Prescription drug benefits

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.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is **\$1,500** for Self Only enrollment and **\$3,000** for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your copayment amounts for eligible medical expenses or eligible prescriptions.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **We use a formulary.** A Plan formulary is a list of Plan-approved prescription drugs. We cover non-formulary drugs prescribed by a Plan doctor.

We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call Client Services at 313/664-8757 or 800/556-9765.

- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply; you pay a \$10 copay per prescription unit or refill for generic drugs, you pay a \$40 copay per prescription unit or refill for brand name drugs when no generic substitute is available or your physician specifically requires the brand name drug. Generic maintenance drugs (those listed on HAP’s Maintenance Drug List) are covered up to a 30-day supply for the \$10 copay per prescription unit or refill. The cost of prescriptions filled at non-Plan pharmacies is reimbursable to the enrollee only for out-of-service emergencies, minus the appropriate copay per prescription or refill.

Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications, should call our Client Services Department at 313/664-8757 or 800/556-9765.

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. Note: If there is no generic equivalent available, you will still have to pay the brand name copay.

Why use generic drugs? Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than a name-brand drug.

When you do have to file a claim. See Section 7 for information of filing a claim for the prescription drug benefits.

Benefit Description	You Pay After the calendar year deductible...
<p>Covered medications and supplies</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"> • Oral contraceptive drugs • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as Not covered. • Insulin • Compounded dermatological preparations • Implanted time-release medications, such as Norplant. For Norplant, you pay the office visit copay per prescription. For other internally implanted time-release medications, you pay the office visit copay. There is no charge when the device is implanted during a covered hospitalization. • Disposable needles and syringes needed to inject covered prescribed medication • Intravenous fluids and medication for home use are covered under Medical and Surgical Benefits • Injectable medications <p>Limited as to number of month’s supply:</p> <ul style="list-style-type: none"> • Smoking cessation drugs and medications including nicotine patches (up to a three-month supply per year) • Drugs for sexual dysfunction (such as Viagra) limited to 4 tablets every 28 days • Injectable infertility drugs • Growth Hormone 	<p>Plan (retail) Pharmacy:</p> <p>§ Generic: \$10 per prescription unit or refill for a 30-day supply;</p> <p>§ Preferred Brand: \$20 per prescription unit or refill for a 30-day supply of preferred brand name</p> <p>§ Non-Preferred Brand: \$50 per prescription unit or refill for a 30-day supply of non-preferred brand name drugs</p> <p>Mail Order (See section 5 (i) for information about our mail order program):</p> <p>§ Generic: \$20 per prescription unit or refill for a 90-day supply;</p> <p>§ Preferred Brand: \$40 per prescription unit or refill for a 90-day supply of preferred brand name</p> <p>§ Non-Preferred Brand: \$100 per prescription unit or refill for a 90-day supply of non-preferred brand name drugs</p> <p>NOTE: If you request a brand name drug and a generic substitute is available, you must pay the generic copay plus the difference in cost between the generic and the brand name drug.</p> <p>If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available.</i> 	<p><i>All charges</i></p>

Section 5(g) Special features

Feature	Description
Flexible Benefit Option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your co-insurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing, but the office visit or inpatient hospital copayment may apply
Dental benefits	
We have no other dental benefits	

Section 5(i) Health education resources and account management tools

Special features	Description
<p>Health education resources</p>	<p>We publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at www.hap.org for more information including:</p> <ul style="list-style-type: none"> • Member Home Page: Health topics of the month • Healthy Living: Information on preventive care and a wide variety of health topics • HAP’s Health Track: A comprehensive disease management Web site from HAP that supports the patient-physician relationship • IStrive: Healthy lifestyle programs to help you prevent disease and improve the quality of your life • Healthcare Advisor: delivers information that helps our members think through their healthcare decisions <ul style="list-style-type: none"> - Drugs/medication interactions - Kids’ health - Patient safety information and - Several other helpful Web site links.
<p>Account management tools</p>	<p>For each HSA and HRA account holder, the fund administrator maintains a complete claims payment history online through at www.HSAmember.com for HSA participants) or www.WageWorks (for HRA participants).</p> <p>Your balance will be shown on your online account and monthly statement from your fund administrator.</p> <p>If you have an HSA,</p> <ul style="list-style-type: none"> • You will receive a statement outlining your account balance and activity for the month. • You may also access your account on-line at www.HSAmember.com . <p>If you have an HRA,</p> <ul style="list-style-type: none"> • Your HRA balance will be available online through www.WageWorks.com . <p>You will receive a statement outlining your account balance and activity for the month.</p>
<p>Consumer choice information</p>	<p>As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.hap.org .</p> <p>Pricing information for medical care is available at www.hap.org . Pricing information for prescription drugs is available at www.hap.org .</p> <p>Link to online pharmacy through www.hap.org .</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.hap.org.</p>
<p>Care support</p>	<p>Patient safety information is available online at www.hap.org</p>

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 313/664-8757 or 800/556-9765 or visit our website at www.hap.org.

New Weight Management Program:

- Members can join **Weight Watchers** within the HAP service area for just \$25 per 12-week session; HAP will pay the rest. As long as members attend 10 out of 12 meetings during a previous session, they can continue for additional 12-week sessions for \$25 per session, up to a total of 4 12-week sessions. To enroll, HAP members can call (800) 3-Florine or enroll online at www.883florine.com. Members will need their ID number to enroll.
- Members can also join **Curves** and save 50% off the total enrollment fee. For those HAP members who attend Curves at least nine times per month, HAP will work with Curves to reimburse the member \$10 toward their monthly dues, for up to 12 consecutive months. To participate, members should show their HAP ID card when they sign up at Curves.

iStrive For Better Health: The HAP **iStrive** for better health online wellness program includes Balance, a weight management and physical activity program. iStrive is available to all HAP members and includes a health risk assessment and healthy lifestyle programs. Members are eligible for rewards when they participate in these programs.

HAP Advantage:

- Global Fit gives members affordable, convenient access to a full range of healthy living options, including flexible membership options to more than 2,000 fitness clubs nationwide, a special low price on the NutriSystem weight-loss program, home exercise options, smoking cessation, stress reduction and more. For details, members should call (800) 294-1500 and identify themselves as HAP members.
- HAP members can also receive discounts on Laser Vision Correction (LASIK) services. No physician referral is needed. Contact HAP's Client Services at 800/556-9765 for more information or visit us on our website at www.hap.org.

Medicare prepaid plan enrollment: This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. Annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan where one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the Plan, ask whether the Plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 313/664-8757 or 800/556-9765 for information on the Medicare prepaid Plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB Plan, call 313/664-8757 or 800/556-9765 for information on the benefits available under the Medicare HMO.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7 Filing a claim for covered services

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.

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. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 313/664-8757 or 800/556-9765.

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

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

Submit your claims to:

Health Alliance Plan
2850 West Grand Boulevard
Detroit, Michigan 48202

Prescription drugs

Submit your claims to:

Health Alliance Plan
2850 West Grand Boulevard
Detroit, Michigan 48202

Other supplies or services

Submit your claims to:

Health Alliance Plan
2850 West Grand Boulevard
Detroit, Michigan 48202

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 benefits for your claim if you do not respond.

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: HAP Grievances, 2850 W. Grand Boulevard, Detroit, Michigan 48202; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

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

- 2** We have 30 days from the date we receive your request to:
 - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

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

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

We will write to you with our decision.

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

You must write to OPM within

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

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group x, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

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

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

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

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.

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 313/664-8757 or 800/556-9765 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 may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

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

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. If we are the secondary payer, we may be entitled to received payment from your primary plan.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

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

• Should I enroll in Medicare?

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

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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

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

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

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 313/664-8757 or 800/556-9765, or you may write to the Plan at 2850 W. Grand Boulevard, Detroit, Michigan 48202. You may also contact the Plan on our Web site at www.hap.org.

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

- **Medicare Advantage (Part C)**

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

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

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we do not waive cost-sharing for your FEHB coverage.

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

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

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

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

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether 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.

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

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

**TRICARE and
CHAMPVA**

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

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

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

**When others are
responsible for 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.

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 14.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page xx.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, co-insurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial Care	Domiciliary care, or basic care including physician services and other ancillary services in a residential, institutional, or other setting or durable medical equipment provided in such settings which is primarily for the purpose of meeting a member's personal needs and which could be provided by persons without professional skills or training. Examples of custodial care include, but are not limited to, assistance with the activities of daily living such as bathing, dressing, eating, walking, getting in and out of bed, and taking medication.
Experimental or investigational service	<p>For the purposes of this Contract HAP bases its determination of whether or not a drug, treatment, device, procedure, service or benefit is experimental or investigational in nature if it meets any of the following criteria:</p> <ul style="list-style-type: none">• It cannot be lawfully marketed without the approval of the FDA and such approval has not been granted at the time of its use or its proposed use; or is the subject of current investigational new drugs or device applications with the FDA.• It is being provided pursuant to Phase I or Phase II clinical trial or as the experimental or research arm of Phase III clinical trial; or is the subject of written protocol which describes its objective, determinations of safety, efficacy, efficacy in comparison to conventional alternatives of toxicity.• It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by federal regulations, particularly those to the FDA or the Department of Health and Human Service.• The predominant opinion among experts as expressed in the published authoritative literature is that the usage should be substantially confined to research settings; or it is not investigational in itself pursuant to any of the foregoing criteria, and would not be medically necessary, but for the provision of a drug, device treatment, or procedure which is “investigational or experimental.” <p>Medical services that are generally regarded by the medical community to be unusual, infrequently provided and not necessary for the protection of health.</p>
Us/We	Us and We refer to Health Alliance Plan
You	You refers to the enrollee and each covered family member.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 14.

Health Reimbursement Arrangement (HRA)

An HRA combines a funding account with a deductible-based medical plan. The HRA is funded by FEHB and those funds can be used to cover qualified medical expenses including the deductibles and copayments associated with your elected Plan. Once you exhaust your HRA total funding amount, Traditional medical coverage begins after you satisfy your deductible. Your HRA funds used to cover medical expenses counts toward your deductible.

Health Savings Account (HSA)

An HSA is a special, tax-advantaged account where money is deposited tax-free, earns interest tax-free and is not taxed when it is withdrawn to pay for qualified medical expenses as listed in Section 213d of the internal revenue code.

Premium pass through contribution to HSA/HRA

The amount of money contributed to your HSA (or HRA if you are not qualified for an HSA) on a monthly basis. In 2008, for each month you are eligible for an HSA premium pass through, HAP will contribute to your HSA \$62.50 for Self Only and \$125 for Self and Family.

Section 11 FEHB Facts

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

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

Children's Equity Act

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2006 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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 (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

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

Temporary Continuation of Coverage (TCC)

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

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

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

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

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

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

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

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

For the HCFSA and LEN HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA – Dental and vision care expenses (but not insurance premiums)

For the DCFSA – daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., EST. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental Insurance

Dental plans will provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with a 24-month waiting period.

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

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

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

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

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dentalvision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

Enrollment types

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

When can I enroll?

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season – November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888-FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

When will coverage be effective?

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on or after December 31, 2006.

How does this coverage work with my FEHB plan's dental or vision coverage?

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Index

Accidental injury	28, 40, 62, 75
Allergy tests.....	56
Allogenic (donor) bone marrow transplant	29
Ambulance.....	32, 34, 66, 68
Anesthesia.....	7, 27, 61
Autologous bone marrow transplant.....	30, 57
Biopsy	27, 61
Blood and plasma.....	51
Catastrophic protection out-of-pocket maximum	33, 78
Changes for 2008.....	10
Chemotherapy.....	57
Cholesterol tests.....	19
Claims.....	80, 81, 90
Coinsurance.....	8, 11, 80, 84, 87
Colorectal cancer screening.....	19
Contraceptive drugs and devices.....	21, 55
Cost-sharing.....	14
Covered charges.....	84
Deductible	25, 59
Dental care.....	40, 75, 95, 96
Diagnostic services.....	17, 18, 32, 37, 54, 67, 71, 95, 96
Disputed claims review.....	41, 76
Durable medical equipment.....	25, 59
Effective date of enrollment	12
Emergency.....	8, 17, 35, 36, 69, 70, 79, 80, 95, 96
Experimental or investigational.....	79
Eyeglasses.....	23, 58
Family planning	21, 55
Fraud.....	5, 6
General exclusions	79
Home health services	25, 60
Hospital.....	6, 7, 8, 11, 12, 17, 24, 25, 27, 28, 30, 31, 32, 33, 36, 37, 40, 59, 61, 62, 64, 65, 66, 67, 70, 72,
Immunizations	8, 19, 51
Infertility.....	21, 56
Inpatient hospital benefits.....	80
Mammogram	51
Maternity benefits.....	20, 55
Medicaid.....	86
Medically necessary.....	18, 27, 32, 35, 37, 38, 40, 52, 53, 54, 61, 66, 69, 71, 73, 75, 79
Medicare.....	37, 71, 83, 85
Members.....	11, 78, 89, 97
Mental Health/Substance Abuse Benefits	37, 71
Newborn care	20, 55
Non-FEHB benefits.....	78
Nurse.....	25, 32, 60, 67
Occupational therapy	22, 57
Office visits.....	8
Oral and maxillofacial surgical.....	29, 63
Out-of-pocket expenses.....	83
Oxygen.....	25, 32, 33, 59, 60, 67
Pap test	18, 19, 54
Physician.....	25, 27, 59, 61
Precertification.....	82
Prescription drugs.....	17, 57, 80, 95, 96
Preventive care, adult.....	19, 52
Preventive care, children.....	20, 53
Preventive services.....	8
Prosthetic devices.....	24, 27, 59, 62
Radiation therapy	57
Room and board.....	32, 66
Second surgical opinion	18, 54
Skilled nursing facility care.....	12, 18, 31, 54, 65
Speech therapy.....	22, 57
Surgery.....	7, 20, 22, 24, 27, 55, 57, 59, 62
Temporary Continuation of Coverage (TCC)	90
Transplants.....	57
Treatment therapies.....	57
Vision care	95, 96
Wheelchairs	25, 59
Workers Compensation.....	86
X-rays	18, 32, 33, 54, 67

Summary of benefits for the HMO Plan Health Alliance Plan - 2008

- **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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$20 specialist	18
Services provided by a hospital:		
• Inpatient	\$250 per admission copay	32
• Outpatient	\$0 per visit	33
Emergency benefits:		
• In-area	\$75 per visit	36
• Out-of-area	\$75 per visit	36
Mental health and substance abuse treatment:	Regular cost sharing	37
Prescription drugs:		
• Retail pharmacy	\$10 generic/\$40 brand	39
• Mail order	\$20 generic/\$80 brand	39
Dental care:	No benefit	40
Vision care:	Limited benefit	23
Special features:	Flexible benefits option	41

Summary of benefits for the HDHP of Health Alliance Plan 2008

Do not rely on this chart alone. All benefits 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.

In 2008 for each month you are eligible for the HSA, will deposit \$62.50 per month for Self Only enrollment or \$125 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you must satisfy your calendar year deductible of \$1,500 for Self Only and \$3,000 for Self and Family before using your HSA. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$750 for Self Only and \$1,500 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (*) means the item is subject to the annual calendar year deductible.

- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your copayments for eligible medical expenses and prescriptions.

Benefits	You pay	Page
Medical services provided by physicians:		54
Diagnostic and treatment services provided in the office	<i>Office visit copay: \$15 primary care, \$25 specialist</i>	54
Services provided by a hospital:		66
• Inpatient	<i>\$250 per admission copay</i>	66
• Outpatient	<i>\$0 per visit</i>	67
Emergency benefits:		69
• In-area	<i>\$75 per visit to an ER</i>	70
• Out-of-area	<i>\$75 per visit to an ER</i>	70
Mental health and substance abuse treatment	<i>Regular cost sharing</i>	71
Prescription drugs:		73
• Retail pharmacy	<i>\$10 generic/\$20 brand/\$50 non-preferred</i>	74
• Mail order	<i>\$20 generic/\$40 brand/\$100 non-preferred</i>	74
Dental care	<i>No benefit</i>	75
Vision care	<i>Limited benefit</i>	58
Special features	<i>Flexible Benefit Option</i>	76
Protection against catastrophic costs (out-of-pocket maximum)	<i>\$5,000 Self Only/\$10,000 Self and Family</i>	46

2008 Rate Information for Health Alliance Plan

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

Postal Category 1 rates apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other career non-law enforcement Postal Service employees. *PostalEASE*, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees, RI 70-2*, to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call.

Human Resources Shared Service Center

1-877-3273, Option 5

TTY: 1-866-260-7507

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	521	\$118.76	\$35.59	\$257.32	\$85.77	\$19.79	\$17.81
High Option Self and Family	522	\$314.73	\$104.91	\$681.92	\$227.30	\$52.45	\$47.21
HDHP Option Self Only	524	\$129.56	\$43.19	\$280.72	\$93.57	\$21.59	\$19.43
HDHP Option Self and Family	525	\$328.71	\$109.57	\$71.21	\$237.40	\$54.78	\$49.52