FEHB Program Carrier Letter
Health Maintenance Organizations (New)

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2014-12(b) **Date: April 15, 2014**

Fee-for-service [n/a] Experience-rated HMO [10] Community-rated HMO [11]

Subject: 2015 Technical Guidance and Instructions for Preparing Benefit and Service Area Proposals for New HMOs

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2015 through December 31, 2015. Please refer to our annual Call Letter (Carrier Letter 2014 - 03) dated March 20, 2014 for policy guidance. Benefit policies from prior years remain in effect unless otherwise noted. The Guidance and instructions are in three parts:

- Part One: Preparing Your Benefit Proposal
- Part Two: Changes in Service Areas or Plan Designation Since You Applied to the FEHB Program
- Part Three: Benefits for Newly-Approved HMOs

This year's deadlines are as follows:

- **Due by May 2, 2014:** Please send your community benefit package and most commonly offered group benefit package.
- **Due by May 31, 2014:** Please send your complete proposal for benefit changes and clarifications to your contract specialist on a CD-ROM (or other electronic means) in addition to a hard copy. Your proposal should include language describing all proposed brochure changes. Your OPM contract specialist will discuss your proposed benefits and finalize negotiations in a close-out letter.
- **Within five business days following receipt of close-out letter or by date set by your contract specialist:** Please send him/her an electronic version of your fully revised 2015 brochure. See Attachment II - Preparing Your 2015 Brochure.

As stated in the Call Letter, proposed benefit changes must be value-based. That means you must demonstrate how you evaluated your proposed benefit changes with regard to their influence on promoting the most effective care (i.e., the care that generally produces the best health outcomes), not just with respect to cost. We are not requiring proposals to be cost neutral by offsetting proposed increases in benefits with reductions elsewhere. However, we will carefully review any benefit proposals that are projected to increase premiums and we expect you to describe in detail the rationale for each proposal and its expected impact on your plan membership.

Enclosed is a checklist (Attachment V) showing all the information to include with your benefit and rate proposals. Please return a completed checklist with your submission.

Rate instructions for community-rated plans and experience-rated plans will be provided under separate cover. Keep in mind that FEHB rate submissions are the cornerstone of our financial relationship with HMOs. We may audit your FEHB rates and their supporting documentation to ensure they are accurate

and reasonable. If you misrepresent your FEHB Program rates, we may take criminal or civil legal actions against the carrier or its officials. We, with the support of the Inspector General's Office and the Justice Department, will aggressively pursue any misrepresentation.

Our experience is that a plan with less than four years of experience in the FEHB Program is most at-risk for dropping out of the Program. Plans that drop out are more likely to cite insufficient FEHB enrollment as the reason for no longer wishing to participate. The FEHB Program is a mature, managed-care market. Your ability to differentiate yourself in terms of pricing, benefits, service, or provider access will go a long way in determining your program success. Keep your lines of communication open with your OPM contract specialist. Please do not hesitate to call if you have any questions about the Call Letter or the material enclosed in this letter.

We appreciate your efforts to timely submit benefit and rate proposals and to produce and distribute brochures. We look forward to working closely with you on these essential activities to ensure a successful Open Season.

Sincerely,

John O'Brien
Director
Healthcare and Insurance

2015 FEHB Proposal Instructions

Part One - Preparing Your Benefit Proposal

Experience-rated Plans

Please send the following by May 2, 2014:

- A copy of a fully executed employer group contract (i.e., *certificate of coverage*) that non-Federal subscribers purchased in 2014.

Please send the following by May 31, 2014:

- You must file your proposed benefit package and the associated rate with your state, if required. If you have made changes since your application, submit a copy of the new benefits description and answer the questions below.

- Attach a chart displaying the following information:

    - Benefits that are covered in one package but not the other

    - Differences in co-insurance, co-pays, numbers of days of coverage and other levels of coverage between one package and the other

    - The number of subscribers/contract holders who currently purchase each package.

Community-rated Plans

We will allow HMOs the opportunity to adjust benefits payment levels in response to local market conditions. If you choose to offer an alternate community package, you should clearly state your business case for the offering. We will only accept an alternate community package if it is in the best interest of the Government and FEHB enrollees.

The alternate benefit package may include greater cost sharing for enrollees in order to offset premiums.

The alternate benefit package may not exclude benefits that are required of all FEHB plans, and may not exclude state mandated benefits. However, other benefits may be reduced or not covered if there is an impact on premiums.

Proposals for alternative benefit changes that would provide premium offset of only minimal actuarial value will not be considered.

Please consult with your contact in the Office of the Actuaries regarding the alternate community package and refer to the rate instructions.

- Submit a copy of a fully executed community benefit package by May 2, 2014 (also known as a master group contract or subscriber certificate), including riders, co-pays, co-insurance, and deductible amounts (e.g. prescription drugs and durable medical equipment) that non-Federal subscribers purchased in 2014. The material must show all proposed benefits for FEHB for the 2015 contract term, except for those still under review by your state. We will accept the community-benefit package that you *project* will be sold to the majority of your non-Federal subscribers in 2015. If you offer a plan in multiple states please send us your community benefit package for each state that you plan to cover.

Note: Your FEHB rate must be consistent with the community-benefit package on which it is based. Benefit differences must be accounted for in your proposal or you may end up with a defective community rate.

All HMOs

Your benefit proposal must be complete. The timeframes for concluding benefit negotiations are firm and we cannot consider late proposals. Your benefit proposal should include:

- Benefit package documentation
- A plain language description of each proposed benefit
- A signed contracting official's form (Attachment I)
- Describe your state's filing process for obtaining approval of benefit packages and changes. Provide a copy of your most recent state submission that applies to the benefit package you sent to us and a copy of the state's approval document. We usually accept proposed benefit changes if you submitted the changes to your state prior to **May 31, 2014,** and you obtain approval and submit approval documentation to us by **June 30, 2014**. Please let us know if the state grants approval by default; i.e., it does not object to proposed changes within a certain period after it receives the proposal. The review period must have elapsed without objection by June 30, 2014.

We will contact the state about benefits as necessary. Please provide the name and phone number of the state official responsible for reviewing your plan's benefits. If your plan operates in more than one state, provide the information for each state.

- Please highlight and address any state mandated benefits. State-mandated benefits should be reported if finalized by May 1, 2014.

If you anticipate significant changes to your benefit package, please discuss them with your OPM contract specialist before you prepare your submission.

Part Two – Changes in Service Areas or Plan Designation Since You Applied to the FEHB Program

Unless you inform us of changes, we expect your proposed service area and provider network to be available for the 2015 contract term. We are committed to providing as much choice to our customers as possible. Given consolidations in the managed-care industry, there are geographic areas where our customers have more limited choices than in other areas.

Please consider expanding your FEHB service area to all areas in which you have authority to operate. This will allow greater choice for our customers. **You must submit in electronic format all ZIP Codes for your existing service area and any new service area expansion that you propose.**

We will provide detailed instructions for submitting your ZIP Code file in September. However, please note that we will ask you to provide your ZIP Codes in a comma delimited text file format and we will provide instructions for uploading your files to our secure web portal.

- **Service Area Expansion** - You must propose any service area expansion by May 31, 2014. We may grant an extension for submitting supporting documentation to us until June 30, 2014.

- **Service Area Reduction** - Explain and support any proposed reduction to your service area. If this reduction applies only to the Federal group, please explain. Please provide a map and precise language to amend the service area description for both expansions and reductions.

Important Notices

- The information you provide about your delivery system must be based on **executed** contracts. We will not accept letters of intent.

- All provider contracts must have "hold harmless" clauses.

Service Expansion Criteria

We will evaluate your service area proposal according to these criteria:

- Legal authority to operate

- Reasonable access to providers

- Choice of quality primary and specialty medical care throughout the service area

- Your ability to provide contracted benefits

- Your proposed service area should be geographically contiguous

You must provide the following information:

- **A description of the proposed expansion area in which you are approved to operate:**

  Provide the proposed service area expansion by ZIP Code, county, city or town (whichever applies), and provide a map of the old and new service areas. Provide the exact wording of how you will describe the service area change in the brochure.

- **The authority to operate in proposed area:**

  Provide a copy of the document that gives you legal authority to operate in the proposed expansion area, and the name and telephone number of the person at the state agency who is familiar with your service area authority.

- **Access to providers:**

  Provide the number of primary care physicians, specialty physicians, and hospitals in the proposed area with whom you have **executed** contracts. Also, please update this information on August 31, 2014. The update should reflect any changes (non-renewals, terminations or additions) in the number of executed provider contracts that may have occurred since the date of our initial submission.

Service and Additional Geographic Areas:

Federal employees and annuitants who live within the service area we approve are eligible to enroll in your plan. If you enroll commercial, non-Federal members from an **additional** geographic area that surrounds, or is adjacent to, your service area, you may propose to enroll Federal employees and annuitants who live in this area. In addition, if the state where you have legal authority to operate permits you to enroll members who **work** but do not reside within your commercial service area, and/or any additional geographic area, you may propose the same enrollment policy for your FEHB Program enrollees. We will provide model language for stating your policy in your brochure.

Benefits may be restricted for non-emergency care received outside the service area. Your proposal must include language to clearly describe any additional geographic area as well as your service area.

Federal Employees Health Benefits Program Statement about Service Area Expansion

(COMPLETE THIS FORM ONLY IF YOU ARE PROPOSING A SERVICE AREA EXPANSION)

We have prepared the attached service area expansion proposal according to the requirements found in the Technical Guidance for 2015 Benefits and Service Area Proposals. Specifically,

1. All provider contracts include "hold harmless" provisions.

2. All provider contracts are fully executed at the time of this submission. I understand that letters of intent are not considered contracts for purposes of this certification.

3. All of the information provided is accurate as of the date of this statement.

_____
Signature of Plan Contracting Official

_____
Title

_____
Plan Name

_____
Date

Part Three – Benefits for Newly-Approved HMOs

The policies established in prior years remain in effect unless we have stated otherwise. You should work closely with your contract specialist to develop a complete benefit package for 2015. For guidance in preparing your proposal for High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA), please refer to Call Letter (Carrier Letter 2008-06) dated March 11, 2008. The FEHB policies include the following:

We expect that you cover state-mandated benefits even if your community package does not specifically reference them unless they are specifically prohibited under FEHB.

As stated in the Call Letter, our primary performance initiatives this year are:

- Optimizing the delivery of prescription drug benefits;
- Enhancing wellness programs;
- Advancing quality of care;
- Ensuring mental health parity;
- Aligning the FEHB Program with the Affordable Care Act; and
- Continuing to encourage programs and benefits that promote enrollment in Medicare Part B.

Please address the Call Letter initiatives in your proposal.

I. CALL LETTER INITIATIVES

A. Prescription Drugs

1. Prescription Drug Cost Trends

Overall drug cost trend is a key indicator of environmental factors, including drug inflation and the introduction of new single-source brand products. It is also a key indicator of the success of pharmacy benefit management strategies that are employed to help assure that the most safe, efficacious, and cost-effective therapies are encouraged.

Overall drug cost trend equals total drug expenditures for the year divided by total drug cost expenditures for the previous year.

2. Utilization Management (2014 & 2015)

A number of utilization management strategies have been widely adopted by pharmacy benefit managers in an ongoing effort to help assure patient safety and to maintain sustainable costs.

3. Member Cost-Share for 2015

It is generally accepted that a reasonable member cost-share helps to reduce overall costs to both the plan and to members; however, increases in cost-share should not be employed as a substitute for effective benefit management.

B. Wellness Programs

1. Health Risk Assessment and Biometric Screening

Carrier Letter 2013-09 required carriers to propose a goal for completion of Health Risk Assessment and a plan for member biometric screening. We requested details about screening parameters and settings, and encouraged member incentives for participation. All carriers responded that blood pressure measurement is included in their biometric evaluation. Carrier Letter 2014-03 (Call Letter) expanded OPM's position on goal setting and incentives.

2. Tobacco Cessation

Carrier Letter 2011-01 documented FEHB requirements for coverage of tobacco cessation benefits. Recent Federal Employee Benefits Survey data show that a majority of current tobacco users want to quit yet are unaware of FEHB tobacco cessation resources. OPM wants to reinforce carrier efforts to promote both the FEHB Tobacco Cessation benefit and tobacco-free living.

C. Advancing Quality and Value of Care

1. Patient Centered Medical Homes

OPM outlined criteria for PCMH in the FEHB Program in Carrier Letter 2013-01. Plans may obtain certification through NCQA, URAC, AAAHC, TJC, or submit alternate criteria to OPM for consideration. All plans requesting approval of alternate criteria during 2013 received written decisions from their contracting officer in early 2014. Any plan seeking approval of alternate criteria this year should contact their contract specialist.

2. Access to Care

Initiatives to enhance member access to care while controlling costs may be implemented in conjunction with PCMH or separately. OPM is interested in learning more about coverage of telehealth and provider extender visits in FEHB plans.

3. Health Plan Accreditation

FEHB health plan accreditation requirements appear in Carrier Letter 2001-19 and Section 1.9 of the FEHB standard contract. We are preparing to publish an updated carrier letter on this topic.

4. Patient Safety

In response to Carrier Letter 2013-09, most carriers chose early elective delivery, antibiotic overuse, or the appropriate use of imaging from among the list highlighted by the Choosing Wisely Campaign. OPM used this information to update HEDIS measures reported by all plans, continuing the measure on imaging for low back pain (LBP) and adding a measure on antibiotic use (AAB) in Carrier Letter 2013-22.

D. Mental Health Parity

Carrier Letter 2013-24 contains OPM's most recent guidance on mental health parity. Carriers are required to comply with the provisions of with 45 C.F.R. s 146.136(c) and submit an

attestation of compliance with their 2015 proposals, including a quantitative parity determination if one has been completed.

Information Required: Please complete Attachment 1a, Mental Health Parity Attestation of Compliance.

E. Aligning the FEHB Program with the Affordable Care Act

1. Preventive Care

All plans must provide coverage of preventive services at no member cost share as required under the Affordable Care Act. Carrier Letter 2014-03 (Call Letter) reaffirms this requirement and directs carriers to updated recommendations issued by the United States Preventive Services Task Force.

In compliance with the Affordable Care Act (ACA), plans must ensure that they provide all preventive services recommended (A or B rating) by the United States Preventive Services Task Force (USPSTF) with no member cost sharing. Carriers should take all necessary steps to prevent enrollees from paying any cost shares associated with USPSTF recommended preventive testing when members follow network referral guidelines. For example, enrollees who use a network facility for mammograms should not receive a separate charge if the radiologist does not participate in the plan's network.

The updated USPSTF recommendations are listed at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. Plans must review this list and make necessary changes to their preventive services in accordance with 45 CFR 147.130(b). For plan year 2015, carriers must provide coverage of all preventive services recommended on or before December 31, 2013. Nine recommendations were added to the list or updated in 2013, including one to screen adults born between 1945 and 1965 for hepatitis C virus infection, and one for low dose computed tomography screening of those at high risk for lung cancer. In addition, all plans must cover immunizations approved by the CDC's Advisory Committee on Immunization Practices as well as Women's Preventive Services endorsed by Health Resources and Service Administration (HRSA) guidelines.[1]

F. Medicare Population Programs and Benefits

The Call Letter asks carriers to propose programs that allow members to maximize benefits under Medicare and the FEHB. These programs should be designed to encourage members to participate in both Medicare Part B and FEHB. These may include pass-through of some or all of the Part B premiums and reductions in cost sharing. We are aware that some carriers offer Medicare Part C (Medicare Advantage) to FEHB members – this is not a request for carriers to offer more Medicare Part C programs.

Information Required: Please provide a description of your proposal for a program to encourage participation in both Medicare Part B and the FEHB. Your proposal should be included in your response to the Call Letter.

[1] http://www.hrsa.gov/womensguidelines/

II. BENEFITS & SERVICES

A. New Guidance

New guidance has been issued by the Department of Health and Human Services, Department of Labor and Department of Treasury for the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. In addition, guidance has been issued for various aspects of the implementation of the Affordable Care Act including coverage of habilitative services and cost-sharing limits (specifically, the out-of-pocket maximum). Please refer to the Call Letter for a description of the guidance and links to appropriate websites.

B. Continued Focus from Previous Years

1. Coverage of Applied Behavior Analysis (ABA)

Recent data indicate that thirty-four states have some level of insurance mandate in place for coverage of Applied Behavior Analysis for children with autism. Additionally, the availability of qualified providers continues to expand. OPM encourages carriers to offer this coverage to FEHB members. We are particularly interested in expanding coverage in states with significant concentrations of federal workers, including CA, CO, CT, DC, MD, NJ, SC, and VA.

2. Organ/Tissue Transplants

We have updated the guidance on organ/tissue transplants for 2015. When you determine that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at that time. Carriers are not obligated to wait for the next contract year before they begin providing such benefits. We have updated the following tables in Attachment III:

Table 1 – OPM's required list of covered organ/tissue transplants.
Table 3 – OPM's recommended list of covered rare organ/tissue transplants

Information Required: Completed Attachment III - 2015 Organ/Tissue Transplants and Diagnoses.

3. Infertility Treatment

We require you to cover diagnosis and treatment of infertility including at least one type of artificial insemination. **This requirement does not include related prescription drugs.** Your brochure language must indicate if you cover or exclude fertility drugs in both the infertility benefit section and the prescription drug benefit section.

4. Reduce Health Disparities

We encourage you to submit proposals that aim to reduce disparities, such as racial and ethnic disparities, in both health status and healthcare. Please provide us with a description of the specific goals and processes you are undertaking or plan to implement in order to reduce health disparities.

5. Actuarial Value

We are requesting additional information on the medical loss ratio for FEHB plans. Please refer to the medical loss ratio defined in both the Affordable Care Act (Public Laws 111-148 & 111-152) and the interim final regulation published by the Department of Health and Human Services on December 1, 2010 (75 FR 74864). We are also requesting your best estimate of the actuarial value for each of your FEHB plan options.

6. Facility Fee for an Office Visit

We would like to clarify that if an enrollee visits a doctor whose office is located in a facility (such as a hospital), the enrollee should only be charged the doctor's co-payment. We have been informed that some enrollees are charged the hospital co-payment in addition to the doctor's copayment. Please ensure that this does not occur.

7. Tobacco Cessation

Carriers must offer smoking cessation programs without co-payments or co-insurance and which are not subject to deductibles, annual or lifetime dollar limits. The programs must include at least two quit attempts per year with up to four smoking cessation counseling sessions of at least 30 minutes each, including proactive telephone counseling, group counseling and individual counseling. In addition to the smoking cessation programs, drugs (over-the-counter (OTC) and prescribed) approved by the FDA to treat tobacco dependence for smoking cessation should be available with no co-payments or co-insurance and not subject to deductibles, annual or lifetime dollar limits. Plans should include OTC drugs in their smoking cessation programs.

Plans must follow the FDA guidelines for all approved drugs. Enrollees who use drugs with multiple purposes, such as Zyban which may be used to treat smoking cessation or depression, must be carefully monitored by a health care professional.

For further information regarding tobacco cessation treatment, please reference the Clinical Practice Guideline, Treating Tobacco Use and Dependence 2008 Update, U.S. Department of Health and Human Services Public Health Service, May 2008. Here is a link to the Guideline: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf

8. Donor Testing Services

We are enhancing benefits related to donor testing services for bone marrow and stem cell transplants and encourage proposals that include testing for up to four bone marrow transplant donors per year. We encourage proposals that include testing for up to four potential bone marrow transplant donors per year from individuals unrelated to the patient, in addition to testing of family members.

9. Assistive Technologies

We encourage you to review your benefits on assistive technologies, including hearing aids, speech generating devices, and prescription drug readers. We also encourage you to offer auditory osseointegrated implants / bone anchored hearing aid (BAHA). Please note that the

BAHA benefit should be listed under orthopedic/prosthetic devices in your plan brochure. For those plans which offer these benefits with dollar limitations, we are encouraging proposals to increase those dollar amounts.

10. Coordination of Benefits

When FEHB Program plans pay secondary COB claims, including those with **Medicare**, they pay the lesser of their allowance or the difference between their allowance and what is paid by the primary plan. You may continue to charge the member co-payments or co-insurance on secondary COB claims. If your benefit design includes co-insurance, it should be based on the remaining charge, not on your allowance. In the following example Medicare is primary and your health plan is secondary. The plan design requires the member to pay 10% co-insurance.

DOS 02/01/10 billed:	$10,000
Medicare allowance:	$9,000
Medicare payment:	$7,200 (80% of allowance)
Balance after Medicare payment:	$1,800
Member responsibility:	$1,800 x 10% = $180
Plan pays:	$1,800 x 90% = $1,620

If your brochure language does not currently describe this process correctly, please work with your contract specialist to ensure that your 2015 Federal brochure correctly describes this process.

11. Catastrophic Limitations

We expect carriers to fully describe their catastrophic limitations for all benefits as well as balance billing for the services of out-of network providers to ensure FEHB enrollees receive appropriate coverage for medically necessary services. We encourage proposals to mitigate any gaps you may have in the catastrophic coverage that you offer.

Please provide a full description of your catastrophic limit(s):

1. Describe the expenses that fall under each of these categories: medical, surgical, mental health and prescription drug benefits.
2. Please indicate completely what expenses are still the member's responsibilities after the member has reached the limit.
3. If you have an out-of-network benefit, please include any payments that members could be responsible for after they have met the catastrophic limit, including provider balance billing. We will consider cost neutral proposals that mitigate the potential for high cost sharing.
4. Given your catastrophic limits, what is the maximum out of pocket expense a member may pay for covered services?

12. Mental Health Parity

The Department of Health and Human Services, Department of Labor, and Department of Treasury released interim final regulations for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Under these rules, health plans cannot have

separate deductible and out-of-pocket maximum requirements that are applicable only with respect to mental health or substance use disorders. This means plans must accrue member expenses toward the same deductibles and out-of-pocket maximums for both medical and surgical benefits and mental health and substance use disorder benefits. In addition, if a health plan has a lower copayment for Primary Care Physician visits, the Plan must use the same copayment level for outpatient visits to providers of mental health or substance use disorder services.

These regulations require parity between medical/surgical and mental health/substance use disorder benefits with respect to financial requirements (copayment, co-insurance, deductibles, and out-of-pocket maximums) or treatment limitations (visit or treatment limit) in the following six classifications: (1) inpatient, in-network, (2) inpatient, out-of-network, (3) outpatient, in-network, (4) outpatient, out-of-network, (5) emergency care, and (6) prescription drug benefits. A financial requirement or treatment limitation must be compared only to a financial requirement or treatment limitation of the same type (co-payments, co-insurance, etc.). For instance, co-payments are compared only to other co-payments; co-payments cannot be compared to co-insurance and vice versa.

In addition, the regulations state a health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant (level of type of financial requirement applied to more than one half) financial requirement or treatment limitation of that type that is applied to substantially all (at least two-thirds) medical/surgical benefits in the same classification. In other words, if co-payments are identified as the financial requirement applied to substantially all medical/surgical benefits (measured by plan costs) in that classification and there are multiple levels of co-payments, the level that applies to more than one half would be considered the "predominant" financial requirement for that classification. Similarly, if a single level applies to at least two-thirds of medical/surgical benefits in a classification, then that level is considered the predominant level that applies to mental health/substance use benefits in that classification. Example: Plan A co-payments apply to at least two-thirds of inpatient/in-network classification and there are two levels of co-payments ($20 & $30); however, the $30 copayment applies to more than one-half of the benefits in that classification, in this case the $30 copayment would be the predominant level.

The regulations prohibit discrimination in the application of non-quantitative treatment limitations, such as medical management standards, prescription drug formulary design, determinations of usual, reasonable and customary amounts, step therapy, and requiring benefits be subjected to a condition such as completing a course of treatment. Any elements used in non-quantitative treatment limitations for mental health benefits must be comparable to those used for medical and surgical benefits. The regulations allow variations to this rule to the extent that recognized clinically appropriate standards of care permit a difference; therefore, concurrent review of mental health care can be required even if the same is not required for medical surgical care.

For further guidance refer to Carrier Letter No. 2008-17 and Letter No. 2009-08 as well as the Interim Final Rules implementing the Act: http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf

13. **Maternity and Mastectomy Admissions**

All plans must provide for maternity benefits. Benefits must be for coverage of admissions of at least 48 hours after a regular delivery and 96 hours after a cesarean delivery, at the mother's option. Similarly, all plans must provide a mastectomy patient the option of having the procedure performed on an in-patient basis and remaining in the hospital for at least 48 hours after the procedure.

14. **Immunizations for Children**

All FEHB plans must provide coverage for childhood immunizations, including the cost of inoculations or serums. Preventive coverage such as immunizations should be covered without a copay.

15. **Dental, Vision and Hearing Benefits**

All plans must cover medically necessary treatment of conditions and diseases affecting eyes and ears, such as glaucoma, cataracts, ruptured ear drums, etc. Beyond treatment for medical conditions by appropriate providers, we will consider dental care (preventive, restorative, orthodontic, etc.), vision care (refractions, lenses, frames, etc.), or hearing care benefits from community-rated plans when these benefits are a part of the core community benefit package that we purchase. It is important that your 2015 brochure language clearly describes your coverage.

16. **Physical, Occupational and Speech therapy**

You must provide coverage for no less than two consecutive months per condition. You may provide a richer benefit, such as 60 visits per condition, if that is your community benefit. You may apply co-pays or co-insurance of up to 50 percent if that is your community benefit. All plans must provide **speech** therapy when medically necessary. If your community package limits speech therapy coverage to rehabilitation only, you must remove that limit for the FEHB Program.

Federal Preemption Authority

The law governing the FEHB Program gives OPM the authority to pre-empt state laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits. We do not pre-empt state laws that increase our enrollees' benefits unless the state mandate conflicts with Federal law, FEHB regulations, or Program-wide policy.

Attachment I
FEHB Carrier Contracting Official

The Office of Personnel Management (OPM) will not accept any contractual action from

_____ (Carrier),
including those involving rates and benefits, unless it is signed by one of the persons named below (including the executor of this form), or on an amended form accepted by OPM. This list of contracting officials will remain in effect until the carrier amends or revises it.

The people named below have the authority to sign a contract or otherwise to bind the Carrier

for _____ (Plan).

Enrollment code (s):_____

Typed name Title Signature Date

_____

_____

_____

_____

_____

By: _____
(Signature of contracting official) (Date)

_____
(Typed name and title)

_____ _____
(Telephone) (FAX)

_____
(Email)

Attachment Ia
Mental Health Parity Attestation of Compliance

Plan Name:

Carrier Codes:

I attest that this plan offers the full continuum of care for mental health and substance use disorder affecting members in any age group. This plan's coverage meets or exceeds mental health parity as defined in the Department of Health and Human Services, Department of Labor, and Department of Treasury final regulations released on November 13, 2013 (http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf). A copy of the quantitative parity determination is included with this plan's 2015 benefits proposal if one has been performed.

Signature of authorized contracting official:

Name **Date**

Title

Attachment II
Preparing Your 2015 Brochure

Summary of Plan Benefits

FEHB plans will continue to provide a summary of plan benefits and coverage (SBC) based on standards developed by the Secretary of the Department of Labor. You will receive additional information regarding the SBC in a subsequent carrier letter.

Going Green

We appreciate your efforts to support our "Going Green" goals to help reduce FEHB administrative costs. You must provide paper copies of plan brochures to new members or only upon request to current members and may send Explanations of Benefits, newsletters and other plan materials electronically.

Timeline: 2015 Brochure Process

We will continue to use the brochure process we implemented last year. This process is a web application that uses database software to generate a Section 508-compliant PDF. This year's deadlines and significant dates are:

DEADLINES	ACTIVITY
May 31	Plans submit Section 5 Benefits information with proposal if suggesting new option
July 2	Plans receive *2015 FEHB Brochure Handbook* via listserv
July 2	OPM will provide *2015 Brochure Creation Tool (BCT) User Manual*
July 9-11 & 14-18	OPM in-house training on the use of the Brochure Creation Tool
July 2-August 29	OPM circulates updated FEHB Brochure Handbook pages by listserv
September 4	Plans must enter all data into Section 5 Benefits and update all plan specific information in the brochure tool. Plans will be unable to make changes after this date so that Contract Specialists can review PDF versions of plan brochures. If changes need to be made, we will unlock plan brochures on a case-by-case basis.
September 10	OPM sends brochure quantity form to plan after Contract Specialist approves brochure for printing as well as other related Open Season instructions
August 22	OPM's deadline to finalize all language and shipping labels

In mid-July, we will provide in-house training to refresh plans on the use of the Brochure Creation Tool with 8 individual sessions held at OPM. We will notify plans via the FEHB Carriers listserv about the training dates and times. Please send any comments or questions pertaining to the Brochure Creation Tool to Lionell Jones at lionell.jones@opm.gov

Attachment III
2015 Organ/Tissue Transplants and Diagnoses

Table 1: Required Coverage

NOTE**: *** indicates an addition to the chart for 2015

I. Solid Organ Transplants: Subject to Medical Necessity	**Reference**
Cornea	Call Letter 92-09
Heart	Call Letter 92-09
Heart-lung	Call Letter 92-09
Kidney	Call Letter 92-09
Liver	Call Letter 92-09
* Pancreas	Call Letter 92-09
*Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	
Intestinal transplants (small intestine with the liver) or (small intestine with multiple organs such as the liver, stomach, and pancreas) or *isolated small intestine	Carrier Letter 2001-18
Lung: Single/bilateral/lobar	Carrier Letter 91-08
Allogeneic transplants for:	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Advanced Hodgkin's lymphoma – relapsed	
Advanced non-Hodgkin's lymphoma - relapsed	
Acute myeloid leukemia	
Advanced Myeloproliferative Disorders (MPDs)	
Amyloidosis	
Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL)	
Hemoglobinopathy	
Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)	
Myelodysplasia/Myelodysplastic Syndromes	
Paroxysmal Nocturnal Hemoglobinuria	
Severe combined immunodeficiency	
Severe or very severe aplastic anemia	
Autologous transplants for:	
Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Call Letter 96-08B
Advanced Hodgkin's lymphoma – relapsed	Call Letter 96-08B
Advanced non-Hodgkin's lymphoma - relapsed	Call Letter 96-08B
Amyloidosis	

Neuroblastoma	Call Letter 96-08B
III. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity	
Allogeneic transplants for:	
Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)	
Autologous transplants for:	
Multiple myeloma	Carrier Letter 94-23, Call Letter 96-08B
Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Carrier Letter 94-23, Call Letter 96-08B
IV. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials.	
Autologous transplants for:	
Epithelial ovarian cancer	Carrier Letter 94-23 Call Letter 96-08B
Childhood rhabdomyosarcoma	
Advanced Ewing sarcoma	
Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms)	Carrier Letter 2013-12a
Advanced Childhood kidney cancers	
Mantle Cell (Non-Hodgkin lymphoma)	
V. Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for member over 60 years of age with a diagnosis listed under Section II): Subject to Medical Necessity	
VI. Tandem transplants: Subject to medical necessity	
Autologous tandem transplants for:	
AL Amyloidosis	
Multiple myeloma (de novo and treated)	
Recurrent germ cell tumors (including testicular cancer)	Call Letter 2002-14

Table 2: Recommended For Coverage: Transplants under Clinical Trials

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services recommended under Clinical Trials. These types of transplants may transition from experimental/investigational and become consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2015?	
Blood or Marrow Stem Cell Transplants	**Yes**	**No**
Allogeneic transplants for:		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Sickle Cell		
Beta Thalassemia Major		
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)		
Non-myeloablative allogeneic transplants for:		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Advanced Hodgkin's lymphoma		
Advanced non-Hodgkin's lymphoma		
Breast cancer		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Colon cancer		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple Myeloma		
Multiple Sclerosis		
Myeloproliferative Disorders		
Myelodysplasia/Myelodysplastic Syndromes		
Non-small cell lung cancer		
Ovarian cancer		
Prostate cancer		
Renal cell carcinoma		
Sarcomas		
Sickle Cell disease		
Autologous transplants for:		
Chronic myelogenous leukemia		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		

Small cell lung cancer		
Autologous transplants for the following autoimmune diseases:		
Multiple sclerosis		
Systemic lupus erythematosus		
Systemic sclerosis		
Scleroderma		
Scleroderma-SSc (severe, progressive)		

Table 3: Recommended For Coverage: Rare Organ/Tissue Transplants

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/ investigational. These types of transplants may transition from experimental/investigational and become consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2015?	
Solid Organ Transplants	**Yes**	**No**
*Allogeneic islet transplantation		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		
Myeloproliferative disorders		
Sickle cell anemia		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom's macroglobulinemia		

Attachment IV
Specialty Benchmark Files

(OPM will provide the specialty benchmark files electronically.)

Attachment V
2015 Technical Guidance Submission Checklist

Topic/Attachment Number	In Proposal Yes/No/NA	Worksheet Completed Yes/No/NA
FEHB Carrier Contracting Official (Attachment I)		
Mental Health Parity Attestation of Compliance (Attachment Ia)		
Preparing Your 2015 Brochure (Attachment II)		
2015 Organ/Tissue Transplants & Diagnoses: Tables 1, 2 & 3 (Attachment III)		
Specialty Benchmark Files (Attachment IV)	N/A	N/A
Technical Guidance Submission Checklist (Attachment V)	N/A	

Please return this checklist with your CY 2015 benefit and rate proposal