

Health Alliance HMO

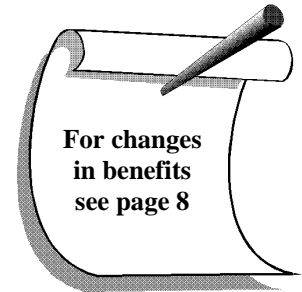
www.healthalliance.org

2006

A Health Maintenance Organization

Serving: *Central, East Central, North Central, Southern and Western Illinois; Western Indiana; and Central Iowa*

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See pages 6 and 7 for requirements.



This Plan has Excellent accreditation from NCQA. See the 2006 Guide for more information on accreditation.

Enrollment codes for this Plan:

FX1 Self Only
FX2 Self and Family



Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the Government Accountability Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

Important Notice from Health Alliance About Our Prescription Drug Coverage and Medicare

OPM has determined that the Health Alliance HMO 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 Health Alliance 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, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 may have to wait until the next open enrollment period 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 <http://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

Table of Contents.....	1
Introduction.....	3
Plain Language	3
Stop Health Care Fraud!	3
Preventing medical mistakes.....	4
Section 1 Facts about this HMO plan	6
How we pay providers	6
Your Rights.....	6
Service Area.....	6
Section 2 How we change for 2006	8
Program-wide changes.....	8
Changes to this Plan.....	8
Section 3 How you get care	9
Identification cards	9
Where you get covered care.....	9
• Plan providers	9
• Plan facilities.....	9
What you must do to get covered care	9
• Primary care.....	9
• Specialty care.....	9
• Hospital care	10
How to get approval for... ..	10
• Your hospital stay	10
• How to precertify an admission	10
• Maternity care.....	10
• What happens when you do not follow the precertification rules when using non-network facilities	11
Circumstances beyond our control.....	11
Services requiring our prior approval	11
Section 4 Your costs for covered services	12
Copayments	12
Deductible.....	12
Coinsurance	12
Your catastrophic protection out-of-pocket maximum	12
Carry Over	12
Section 5 Benefits	
High Option Benefits	13
Non-FEHB benefits available to Plan members	41
Section 6 General exclusions - things we don't cover	42
Section 7 Filing a claim for covered services	43
Section 8 The disputed claims process.....	44
Section 9 Coordinating benefits with other coverage	46
When you have other health coverage	46
What is Medicare?	46
• Should I enroll in Medicare?.....	46
• The Original Medicare Plan (Part A or Part B).....	47
• Medicare Advantage (Part C)	47
• Medicare prescription drug coverage (Part D).....	48
TRICARE and CHAMPVA.....	50

Workers' Compensation	50
Medicaid	50
When other Government agencies are responsible for your care.....	50
When others are responsible for injuries.....	50
Section 10 Definitions of terms we use in this brochure.....	51
Section 11 FEHB facts	52
Coverage information	52
• No pre-existing condition limitation	52
• Where you get information about enrolling in the FEHB Program	52
• Types of coverage available for you and your family.....	52
• Children's Equity Act	52
• When benefits and premiums start.....	53
• When you retire	53
When you lose benefits.....	53
• When FEHB coverage ends	53
• Spouse equity coverage.....	53
• Temporary Continuation of Coverage (TCC).....	54
• Converting to individual coverage.....	54
• Getting a Certificate of Group Health Plan Coverage.....	54
Section 12 Two Federal Programs complement FEHB benefits.....	55
The Federal Flexible Spending Account Program – <i>FSAFEDS</i>	55
The Federal Long Term Care Insurance Program.....	58
Index	60
Summary of benefits for the Health Alliance HMO Plan – 2006	61
2006 Rate Information for Health Alliance HMO	Back cover

Introduction

This brochure describes the benefits of Health Alliance Medical Plans, Inc., on behalf of itself and Health Alliance Midwest, Inc., its wholly owned subsidiary, under our contract (CS 1980) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for the Health Alliance Medical Plans, Inc. administrative offices is:

*Health Alliance HMO
301 S Vine Street
Urbana, IL 61801*

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 8. 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 HMO.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, 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 (FEHB) 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 you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your Plan physician, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your Plan physician 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 1-800-851-3379 and explain the situation.

If we do not resolve the issue:

**CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:
**The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415**

- 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 Plan physician with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.

- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

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

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

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

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but also to help choose quality healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.talkaboutrx.org/index.jsp. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.
- 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 healthcare 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. You can also view our provider directory at our Web site www.healthalliance.org.

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

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

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

How we pay providers

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

Your Rights

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

Health Alliance is a unique managed care organization because physicians own it. Health Alliance Medical Plans, Inc., is the corporate successor to CarleCare, Inc., a not-for-profit health maintenance organization founded by one of the largest multi-specialty group practices in the nation – Carle Clinic Association, P.C., in Urbana, Illinois. CarleCare HMO enrolled its first member in March 1980 and, five years later, became a federally qualified HMO. In 1989, CarleCare was reorganized as a for-profit domestic insurance company owned by Carle Clinic and renamed Health Alliance Medical Plans. As such, Health Alliance can underwrite and administer a full range of managed care products.

Today, Health Alliance is the largest managed care organization based in downstate Illinois, covering most of central and east central Illinois, as well as numerous counties in southern, north central, and western Illinois and central and eastern Iowa. The corporate office is located in Urbana, Illinois.

Health Alliance provides convenient access to health care with a large network of quality providers. Physicians and specialists as well as clinics, hospitals, pharmacies, and other providers were selected to be part of the Health Alliance provider network because of their reputation for excellence.

If you want more information about us, call 1-800-851-3379, or write to Health Alliance Medical Plans, 301 South Vine Street, Urbana, IL 61801. You may also contact us by fax at (217) 255-4699 or visit our Web site at www.healthalliance.org.

Service Area

To enroll in this Plan, you must live or work in one of our service areas. This is where our providers practice. A service area is a geographic region consisting of one or more counties. The county in which you live or work determines your service area and, subsequently, your provider network. When you enroll in the Plan, you will be required to select a Primary Care Physician in your service area. This physician will coordinate all of your medical care.

Should you require specialty or ancillary care, your Primary Care Physician will refer you to a provider in your service area. It is your responsibility to make sure your Primary Care Physician refers you to Plan physicians. Please refer to your provider directory or

contact us at 1-800-851-3379. You can also view your provider directory at our Web site www.healthalliance.org. If you require care that is not available within your service area, your physician will request an out-of-network referral from a Plan medical director. The Plan will notify the referring physician and you in writing of the decision. To assure coverage, please be sure the out-of-network service has been approved prior to seeking services. Our service areas are listed below.

Our Illinois service areas are:

Decatur St. Mary's: **Illinois County:** Macon

DeKalb Service Area: **Illinois Counties:** Boone, DeKalb, and Winnebago

East Central Illinois Service Areas: **Illinois Counties:** Champaign, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Effingham, Fayette, Ford, Grundy, Iroquois, Jasper, Kendall, LaSalle, Livingston, McLean, Moultrie, Piatt, Shelby, Tazewell, Vermillion, and Woodford

East Central Illinois Service Area: **Indiana Counties:** Fountain, Vermillion, and Warren

Macomb Service Area: **Illinois Counties:** Henderson, McDonough, and Warren

Peoria Service Area: **Illinois Counties:** Peoria, Knox, Stark, Tazewell, and Woodford

Quad Cities Service Area: **Illinois Counties:** Henry, Mercer, and Rock Island

Quad Cities Service Area: **Iowa Counties:** Scott

Quincy Service Area: **Illinois Counties:** Adams, Brown, Hancock, Pike, and Schyuler

South Central Service Area: **Illinois Counties:** Clay, Crawford, Edwards, Hamilton, Jefferson, Lawrence, Marion, Richland, Wabash, Wayne, and White.

Southern Illinois Service Area: **Illinois Counties:** Franklin, Gallatin, Hardin, Jackson, Johnson, Perry, Randolph, Saline, Union, Washington, and Williamson

Southern Tip: **Illinois Counties:** Alexander, Massac, Pope, and Pulaski

Springfield Service Area: **Illinois Counties:** Cass, Christian, Greene, Jersey, Logan, Macoupin, Mason, Menard, Montgomery, Morgan, Sangamon, and Scott

Sterling Rock Falls Service Area: **Illinois Counties:** Bureau, Carroll, Lee, Ogle, and Whiteside

Our Iowa service area is:

Central Iowa Service Area: **Iowa Counties:** Boone, Calhoun, Carroll, Dallas, Greene, Hamilton, Hardin, Jasper, Marshall, Polk, Story, Tama, Webster, and Wright

Ordinarily, you must get your care from providers who contract with us. If you receive care outside your service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of your service area unless the services have prior Plan approval.

If you or a covered family member moves outside of your 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 family member moves, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2 How we change for 2006

Do not rely on these change descriptions; this page 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 this Plan

- Your share of the non-Postal premium will increase by 16.3% for Self Only or 16.2% for Self and Family.

Section 3 How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-851-3379 or write to us at Health Alliance, 301 South Vine Street, Urbana, IL 61801. You may also request replacement cards through our Web site at www.healthalliance.org.

Where you get covered care

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

• Plan providers

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

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

• 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 at www.healthalliance.org.

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.

• Primary care

Your Primary Care Physician can be a family practitioner, internist, or pediatrician. Your Primary Care Physician will provide most of your health care or 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 receive optometric care for routine eye exams and females may see a Woman’s Principal Health Care Provider without a referral. You are responsible for making sure your Primary Care Physician refers you to an in-network specialist. Please refer to your provider directory or you can view our provider directory on our Web site at www.healthalliance.org.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your Primary Care Physician will work with the 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 or disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

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

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

• Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 1-800-851-3379. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

How to get approval for...

• Your hospital stay

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.

• How to preauthorize an admission

Preauthorization must be obtained from Health Alliance when your Primary Care Physician recommends a referral to a non-participating provider or a provider outside of your service area. Your Primary Care should obtain preauthorization on your behalf by calling or submitting a completed preauthorization request form to Health Alliance prior to receipt of services. You are responsible for ensuring the attending physician has received preauthorization, and Health Alliance has approved coverage for the requested services.

If the preauthorization request is approved, both you and your Primary Care Physician will be notified of the effective dates and the care services you are authorized to receive. Once your preauthorization approval expires, it is your responsibility to notify your Primary Care Physician so he/she can determine whether further care is needed, and if so, request another preauthorization from Health Alliance.

If your preauthorization is denied, Health Alliance will not provide coverage for the requested services.

• Maternity Care

You do not need to preauthorize your normal delivery at a participating provider. Your Plan Primary Care Physician or specialist will make necessary hospital arrangements and supervise your care.

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

Health Alliance will not cover services rendered by a non-participating provider, except for emergency services, unless your Primary Care Physician refers you and you receive preauthorization from Health Alliance

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 preauthorization. Your physician must obtain approval before sending you to a provider outside your service area or to a non-Plan provider. Before giving approval, we consider if the service is medically necessary and if it follows generally accepted medical practice.

Preauthorization is also required for services such as durable medical equipment, home health care, home infusion services, hospice care, infertility services, organ transplants, bariatric surgery, specialty prescription drugs, prosthetic devices, reconstructive surgery, and spinal manipulations for assurance that the service, procedure, or supply is medically necessary and will be covered.

Medical necessity determination of covered health care services under this Plan is subject to the medical policies presently in effect and adopted or amended by Health Alliance HMO. A copy of the medical policies and procedures relevant to a pending coverage decision will be made available to members upon written request.

Section 4 Your costs for covered services

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

Copayments

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

Example: When you see your Primary Care Physician, you pay a copayment of \$15 per office visit and when you go in the hospital, you pay \$250 per admission.

Deductible

We do not have a deductible.

Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: In our Plan, you pay 20% of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum

After your copayments and/or coinsurance totals \$1,500 per person or \$3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services:

- Durable medical equipment
- Prosthetic devices
- Prescription drugs
- Vision care

You have a separate out-of-pocket maximum for specialty prescription drugs of \$500 per person or \$1000 per family. See Section 5(a) for specific information on coverage of specialty prescription drugs.

Be sure to keep accurate records of your copayments or coinsurance 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.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

Benefits

See page 8 for how our benefits changed this year. Page 61 is a benefits summary. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5 Benefits Overview	13
Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	15
Diagnostic and treatment services.....	15
Lab, X-ray, and other diagnostic tests.....	16
Preventive care, adult.....	16
Preventive care, children.....	17
Maternity care	18
Family planning	18
Infertility services	19
Allergy care.....	19
Treatment therapies.....	19
Specialty Prescription Drugs.....	20
Physical and occupational therapies	20
Speech therapy	21
Hearing services (testing, treatment, and supplies).....	21
Vision services (testing, treatment, and supplies)	21
Foot care	21
Orthopedic and prosthetic devices	22
Durable medical equipment (DME).....	22
Home health services	23
Chiropractic	23
Alternative treatments.....	24
Educational classes and programs.....	24
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	25
Surgical procedures.....	25
Reconstructive surgery.....	26
Oral and maxillofacial surgery.....	26
Organ/tissue transplants.....	27
Anesthesia.....	28
Section 5(c) Services provided by a hospital or other facility, and ambulance services.....	29
Inpatient hospital.....	29
Outpatient hospital or ambulatory surgical center	30
Extended care benefits/skilled nursing care facility benefits	31
Hospice care.....	31
Ambulance.....	31
Section 5(d) Emergency services/accidents	32
Emergency within our service area	33
Emergency outside our service area.....	33
Ambulance	33
Section 5(e) Mental health and substance abuse benefits	34
Section 5(f) Prescription drug benefits	36
Section 5(g) Special features	39
Flexible benefits option	39
Services for the deaf and hearing impaired	39
Reciprocity benefit.....	39

Section 5(h) Dental benefits 40
 Accidental injury benefit..... 40
 Dental benefit..... 40
Section 5(i) Non-FEHB benefits available to Plan members 41
Summary of benefits for the Health Alliance HMO Plan – 2006 61
2006 Rate Information for Health Alliance HMO back cover

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.
- An outpatient surgical facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- 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	
Professional services of physicians, nurse practitioners, nurses, or physician's assistants <ul style="list-style-type: none"> • In physician's office 	\$15 per office visit.
Professional services of physicians <ul style="list-style-type: none"> • In an urgent-care center • Office medical consultations • Second surgical opinion 	\$15 per office visit.
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled-nursing facility 	Nothing if you are an inpatient in a hospital or skilled nursing facility. You pay only your hospital admission copayment.
At home	\$20 per visit.

Diagnostic and treatment services— continued on next page

Lab, X-ray, and other diagnostic tests	You Pay
<p>Tests, such as:</p> <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 	<p>Nothing. You pay only your \$15 per office visit copayment.</p>
Preventive care, adult	
<p>Routine physical every year which includes:</p> <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total blood cholesterol – once every three years. This includes fasting lipoprotein profile for cholesterol/lipid screening. • Colorectal cancer screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Double contrast barium enemas – every five years starting at age 50 • Osteoporosis screening 	<p>\$15 per office visit.</p>
<ul style="list-style-type: none"> • Colorectal cancer screening, including <ul style="list-style-type: none"> – Sigmoidoscopy, screening – every five years starting at age 50 – Colonoscopy – every ten years starting at age 50 	<p>\$100 copay per outpatient surgical admission when the service is provided in an outpatient hospital setting or outpatient surgical facility.</p>
<p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p>	<p>Nothing. You pay only your \$15 per office visit copayment.</p>
<p>Routine Pap test</p> <p>Note: You do not pay a separate copayment for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i>, above.</p>	<p>Nothing. You pay only your \$15 per office visit copayment.</p>

Preventive care, adult– continued on next page

Preventive care, adult <i>(continued)</i>	You pay
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 	Nothing. You pay only your \$15 per office visit copayment.
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and older (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	Nothing. You pay only your \$15 per office visit copayment.
<i>Not covered:</i> <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>All charges.</i>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing. You pay only your \$15 per office visit copayment.
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations, and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> – Eye exams through age 17 to determine the need for vision correction – Hearing exams to determine the need for hearing correction – Examinations done on the day of immunizations (up to age 22) 	\$15 per office visit.

Maternity care	You pay
<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 do not need to preauthorize your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5b). • We cover circumcision for male infants under Surgical benefits (Section 5(b)). 	<p>\$50 copayment per pregnancy. Care provided by specialists during prenatal period is subject to the \$15 office visit copayment.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Routine sonograms to determine fetal age, size, or sex 	<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 Prescription drug benefits.</p>	<p>Nothing. You pay only your \$15 office visit copayment.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilization • Genetic counseling 	<p><i>All charges.</i></p>

Infertility services	You pay
<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) • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> – in vitro fertilization – embryo transfer, gamete GIFT and zygote ZIFT – zygote transfer • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under Prescription drug benefits.</p>	<p>\$15 per office visit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services and supplies related to excluded ART procedures</i> • <i>Non-medical cost of donor sperm</i> • <i>Non-medical cost of donor egg</i> • <i>Infertility service after voluntary sterilization</i> 	<p><i>All charges.</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injection 	<p>\$15 per office visit.</p>
<p>Allergy serum</p>	<p>Nothing.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing and 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 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 	<p>\$15 per office visit.</p> <p>Nothing per visit during covered inpatient admission.</p>

Specialty Prescription Drugs	You pay
<ul style="list-style-type: none"> Specialty Prescription Drugs <p>Some Specialty Prescription Drugs are covered when provided by a Participating Provider. Coverage is subject to prior written order by your Physician and Preauthorization by a Medical Director. To be consistent with changes in medical technology, Health Alliance will maintain a list of covered Specialty Prescription Drugs and the medical conditions for which they are approved for coverage. Examples of Specialty Prescription Drugs include: Interferons, Erythropoietin, and granulocyte colony stimulating factor (G-CSF). Coverage can be verified by calling the Customer Service Department at 1-800-851-3379.</p> <ul style="list-style-type: none"> Growth hormone therapy (GHT) Note: We will only cover GHT when we preauthorize the treatment. Call 1-800-851-3379 for preauthorization. We will ask you to submit information that establishes the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3. 	<p>20% Coinsurance.</p> <p>Out-of-pocket maximum, per calendar year.</p> <p>\$500 per member.</p> <p>\$1,000 per family.</p>
Physical and occupational therapies	
<ul style="list-style-type: none"> A combined total of 60 visits per condition per calendar year for the outpatient services of each of the following: <ul style="list-style-type: none"> qualified physical therapists 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> <p>Inpatient rehabilitation services are covered under the Extended care benefits/skilled nursing facility benefits/rehabilitation benefits heading of Section 5(c) Services provided by a hospital or other facility, and ambulance services on page 29.</p> <ul style="list-style-type: none"> Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction, is provided for up to 24 sessions in 12 consecutive weeks or less for Phase II. Phase I cardiac rehab is provided in the hospital after surgery. 	<p>\$15 per office visit.</p> <p>\$15 per outpatient visit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Long-term rehabilitative therapy Exercise programs Phase III cardiac rehabilitation 	<p><i>All charges.</i></p>

Speech therapy	You pay
<ul style="list-style-type: none"> 60 visits per condition per calendar year 	\$15 per office visit. \$15 per outpatient visit. Nothing per visit during covered inpatient admission.
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> First hearing aid and testing only when necessitated by accidental injury Hearing screenings and evaluations Note: See <i>Preventative care, children</i> for hearing screening for children.	\$15 per office visit.
<i>Not covered:</i> <ul style="list-style-type: none"> Hearing aids, testing, and examinations for them 	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	\$15 per office visit.
<ul style="list-style-type: none"> Annual eye refractions Note: See <i>Preventative care, children</i> for eye exams for children.	\$15 per office visit.
<i>Not covered:</i> <ul style="list-style-type: none"> Eyeglasses or contact lenses, except as shown above Eye exercises and orthoptics Radial keratotomy and other refractive surgery 	<i>All charges.</i>
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes See Orthopedic and prosthetic devices for information on podiatric shoe inserts	\$15 per office visit.
<i>Not covered:</i> <ul style="list-style-type: none"> Cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above Treatment of weak, strained, or flat feet, bunions, or spurs; and of any instability, imbalance, or subluxation of the foot (unless the treatment is by open cutting surgery) 	<i>All charges.</i>

Orthopedic and prosthetic devices	You pay
<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 are paid as hospital benefits; see Section 5(c) for payment information. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Foot orthotics • Lumbosacral supports 	20% coinsurance.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes (except for diabetic shoes when medical criteria is met)</i> • <i>Arch supports</i> • <i>Heel pads and heel cups</i> • <i>Prosthetic replacements provided less than five years after the last one we covered, unless it is irreparable and member has properly maintained it</i> 	<i>All charges.</i>
Durable medical equipment (DME)	
<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 • Insulin pumps <p>Note: Call us at 1-800-851-3379 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>	20% coinsurance.

Home health services	You pay
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), or home health aide • Services include oxygen therapy, intravenous therapy, and medications. 	\$15 per office visit.
<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	
<ul style="list-style-type: none"> • Manipulation of the spine and extremities is covered if referred by the Primary Care Physician and approved by a medical director. • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application are covered as rehabilitative therapy services and are subject to 60 treatments per condition per calendar year. Hot/cold pack therapy used in conjunction with approved manipulation and mobilization is covered. X-rays and other diagnostic testing are covered under diagnostic and treatment services and must be provided by a Plan provider. <p>Note: Spinal manipulations and mobilizations are covered when long-term significant improvement can be expected from such treatment.</p>	\$15 per office visit.

Alternative treatments	You pay
Biofeedback – under certain circumstances	\$15 per office visit.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Acupuncture</i> 	<i>All charges.</i>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self-management 	\$15 per office visit.
<ul style="list-style-type: none"> • Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Health Alliance offers <i>I Can Quit</i>, a telephone-based smoking cessation program. Interested members may call 1-866-345-5129 to determine their readiness to quit. If they are ready, they may enroll in the two-month program and choose the level of telephone support they want from our trained health coaches. Enrollees will receive a free quit kit by mail. In addition, the member’s health coach will follow up with the member and the member’s physician throughout the year. Enrollees are eligible for up to two months of either nicotine replacement therapy or Zyban ® for a \$15/month copayment. These medications must be obtained by prescription for the copayment to apply. Members are eligible to enroll in <i>I Can Quit</i> once per 12 month period, twice per lifetime. <p>Note: Members can elect only one of the options above.</p>	<p>All charges over the \$100 smoking cessation benefit.</p> <p>Option of purchasing up to two months of nicotine replacement therapy (requires a prescription) or prescription Zyban ® for a \$15/month copayment at Plan pharmacies through the <i>I Can Quit</i> program.</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.
- 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 PREAUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which services and surgeries require preauthorization.

Benefit Description	You pay
<p>Surgical procedures</p> <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 if medical criteria set by Plan is met (bariatric surgery). See <i>Services requiring our approval</i> on page 11. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., tubal ligation) (vasectomy only covered in physician’s office) • 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 Surgical benefits for insertion of the pacemaker.</p>	<p>\$15 per office visit.</p> <p>or</p> <p>Nothing if you are inpatient in a hospital. You pay only your hospital admission copayment.</p>
<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	You Pay
<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 on the other breast – 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 office visit.</p> <p>or</p> <p>Nothing if you are inpatient in a hospital. You pay only your hospital admission copayment.</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>
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 • Other surgical procedures that do not involve the teeth or their supporting structures 	<p>\$15 per office visit.</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	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas <p>Limited Benefits – Treatment for breast cancer, multiple myeloma and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>Transportation, lodging, and meals for the transplant recipient and a companion for travel to and from a Plan designated center of excellence is covered. If the patient is a minor, transportation and reasonable and necessary lodging and meal costs for two persons who travel with the minor are included. Expenses for meals and lodging are reimbursed at the per diem rates established by the Internal Revenue Service.</p>	<p>Nothing.</p>
<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>Experimental organ or tissue transplants</i> 	<p><i>All charges.</i></p>

Anesthesia	You pay
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing. You pay only your hospital admission copayment.
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	Nothing.
Professional services provided in – <ul style="list-style-type: none"> • Office 	Nothing. You pay only your office visit copayment.

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 covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • ward, semiprivate or intensive care accommodations • general nursing care • meals and special diets <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$250 per admission.

Inpatient hospital -- continued on next page

Inpatient hospital <i>(continued)</i>	You pay
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • 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 • Rehabilitative services 	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, and schools • Personal comfort items, such as telephone, television, barber services, guest meals, and beds • Private nursing care 	<i>All charges.</i>
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>	\$100 copay per outpatient surgical admission.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Blood and blood derivatives not replaced by the member 	<i>All charges.</i>

Extended care benefits/skilled nursing care facility benefits/rehabilitation services	You Pay
<p>Extended care benefit: Up to a combined total of 120 days per calendar year for rehabilitative therapy and skilled nursing care in an approved nursing facility. Rehabilitative services received in an acute inpatient setting apply towards the combined total of 120 days per calendar year.</p>	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> 	<i>All charges.</i>
Hospice care	
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient or outpatient care and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately 12 months or less.</p>	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing, homemaker services</i> 	<i>All charges.</i>
Ambulance	
<p>Local professional ambulance service when medically appropriate</p>	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.
- 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 Primary Care Physician. In extreme emergencies, if you are unable to contact your Primary Care Physician, call 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. You or your family member should notify the Plan within 48 hours after care begins unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified in a timely manner.

If you need to be hospitalized, the Plan must be notified within 48 hours after care begins or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and the Plan physicians believe 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, follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan physicians.

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

If you need to be hospitalized, the Plan must be notified within 48 hours after care begins 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 physician 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, follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan physicians.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a Plan physician’s office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including Plan physicians’ services <p>Note: If admitted, the emergency room copayment is waived and you pay the \$250 inpatient hospital admission copayment.</p>	<p>\$15 per office visit.</p> <p>\$15 per office visit.</p> <p>\$100 per emergency room 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 physician’s office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including physicians’ services 	<p>\$15 per office visit.</p> <p>\$15 per office visit.</p> <p>\$100 per emergency room visit.</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	
<p>Professional ambulance service when medically appropriate</p> <p>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 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.
- 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	
<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>\$15 per visit.</p>

Mental health and substance abuse benefits – continued on next page

Mental health and substance abuse benefits <i>(continued)</i>	You pay
<ul style="list-style-type: none"> Diagnostic tests 	Nothing.
<ul style="list-style-type: none"> Services provided by a hospital or other facility Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, or facility based intensive outpatient treatment. 	\$250 per admission.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Services we have not approved</i> <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>	<i>All charges.</i>

Preauthorization

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

Except in a medical emergency or when a Primary Care Physician has designated another Plan physician to see patients when he or she is unavailable, you must contact your Primary Care Physician for a referral before seeing any other Plan physician or obtaining specialty services. Referral to a Plan specialist in your service area is given at the Primary Care Physician's discretion. If specialists or consultants are required beyond those participating in the Plan, a Plan medical director must make the approval.

A list of the Plan's mental health/substance abuse providers can be found in the Plan's provider directory for your service area or you may contact the Customer Service Department at 1-800-851-3379 to see which mental health/substance abuse providers participate with the Plan in your service area.

Limitation

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

Section 5 (f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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 may fill the prescription at a Plan pharmacy or by mail order. Health Alliance offers mail order service through Walgreens for members on covered maintenance medications. If you are taking a maintenance medication, you can receive a 90-day supply by mail for three copayments. To participate, ask your Plan physician to write a special 90-day prescription for you to mail to Walgreens. You can contact our Customer Service Department at 1-800-851-3379 to request a mail order form.

- **We use a formulary.** The Plan has a tiered pharmacy copayment structure for each 30-day supply. To keep your costs as low as possible, we ask that you and your physician select appropriate medicines from the list. We have an open formulary. However, the Plan recognizes the value of using FDA-approved generic drugs whenever medically appropriate. For this reason, you will always pay the lowest copayment for generic drugs. If your physician believes a brand-name product is necessary or there is no generic available, your physician may prescribe a brand-name drug from the formulary list. This list of brand-name drugs is a preferred list of drugs that we selected to meet patient's needs at a lower cost. When a generic drug doesn't exist, brand-name drugs that are not on our preferred list require the highest copayment level. To order a prescription drug brochure, call 1-800-851-3379 or you can view our formulary on our Web site, www.healthalliance.org.

- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral physician and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply.

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

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- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure these drugs meet the same standards of quality and strength as brand-name drugs.
 - **When you have to file a claim.** If you have to pay out-of-pocket for a prescription because you do not have your ID Card, please contact our Customer Service Department at 1-800-851-3379 for information on submitting your claim.
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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"> • Prescription drugs prescribed by a Plan or referral physician and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply or manufacturer’s standard package. You pay a \$10 copayment per prescription unit or refill for Tier 1 drugs (mainly generic drugs), a \$20 copayment for Tier 2 (brand-name on formulary), and a \$40 copayment for Tier 3 (brand-name non-formulary). If the physician allows substitution and the member prefers a brand-name drug on the formulary instead of the generic (if available), the member pays \$10 plus the difference in cost between the generic and the brand-name drug. If the physician does not allow substitutions, the member will pay the \$20 copayment. • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (when the following conditions are met and preauthorized by the Plan) <ul style="list-style-type: none"> – Must be medically necessary – Member must be 18 years or older – Covered quantity limited to four tablets per 30-day period – Member cannot be on nitrates – No coverage for women • Contraceptive drugs • Certain prescription drugs are covered under the medical benefits of this Plan and are not paid for at the dispensing pharmacy. These include, but are not limited to, immunization agents, antigens, allergy and biological sera, drugs or drug products derived from blood or blood plasma, radiologicals and recombinant biologicals (i.e., Interferon, Erythropoietin, Human Growth Hormone, etc.) • Some prescription drugs require preauthorization from a Plan medical director and certain criteria to be met by the member. The member’s physician must contact the Plan to obtain preauthorization. To accord with changes in medical technology, the Plan maintains a list of pharmaceuticals that require preauthorization. The list is available to the member upon request. Failure to obtain preauthorization may result in the dispensing pharmacy requiring personal payment from the member. 	<p>At a Plan pharmacy:</p> <p>\$10 Tier 1. \$20 Tier 2. \$40 Tier 3.</p> <p>Through mail order per 90 day supply:</p> <p>\$30 Tier 1. \$60 Tier 2. \$120 Tier 3.</p> <p>Mail order copayments are based upon a 90-day supply. You pay three copayments for a 90-day supply.</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand-name copayment.</p>

Covered medication and supplies – continued on the next page

Covered medications and supplies <i>(continued)</i>	You pay
<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>Non-prescription medicines</i> • <i>Drugs for which there is a non-prescription equivalent available</i> • <i>Medical supplies, such as dressings and antiseptics</i> 	<p><i>All charges.</i></p>

Section 5 (g) Special features

Feature	Description
Flexible benefits 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
Services for deaf and hearing impaired	TTY 1-866-883-8551
Reciprocity benefit	The Plan offers a reciprocity program for family members living temporarily away from home in an area serviced by the Plan. Under this program, family members living away can receive coverage for medically necessary routine care. For additional information on this program, or to enroll a family member, call the Customer Service Department at 1-800-851-3379.

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.
- Hospitalization for dental work will be covered for children age 6 and under; individuals with a medical condition that requires hospitalization or general anesthesia for dental care; or individuals who are disabled when Preauthorized by a Medical Director.
- **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

We have no other dental benefits.

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

Medicare prepaid plan enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 47, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to suspend their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join the 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 suspending your FEHB enrollment and changing to a Medicare prepaid plan. Contact the Plan at 1-800-965-4022 for information on the Medicare prepaid plan and the cost of that enrollment.

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.

Section 6 General exclusions – things we don't cover

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

We do not cover the following:

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

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 or coinsurance.

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

Medical and hospital benefits

In most cases, providers, and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-851-3379.

When you must file a claim - such as for services you receive outside of 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)
- Receipts, if you paid for your services

Submit your claims to: Health Alliance Medical Plans
301 S Vine Street
Urbana, IL 61801

Prescription drugs

All Plan pharmacies will file your claim electronically with you only being responsible for your copayment. However, if for any reason you had to pay for your prescriptions out of pocket, please call the Customer Service Department at 1-800-851-3379 for information on submitting your claim.

Deadline for filing your claim

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

When we need more information

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

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:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">(a) Write to us within 6 months from the date of our decision; and(b) Send your request to us at: Health Alliance Medical Plans, 301 South Vine Street, Urbana, IL 61801; and(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">(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	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">• 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. <p>Write to OPM at: Office of Personnel Management, Insurance Service Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.</p>

The Disputed Claims process (*Continued*)

Send OPM the following information:

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

Note: If you want OPM to review 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 1-800-851-3379 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 2 at 202-606-3818 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 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.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has 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. (Someone who was a Federal employee on January 1, 1983, or since automatically qualifies.) 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). There is a monthly premium 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 the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security administration toll-free number 1-800-772-1213 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 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 physician, 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. Your care must continue to be authorized by our Plan Primary Care Physician and preauthorized, as required. We will waive copayments and coinsurance on all services except prescription drugs if you use the Plan providers and follow Plan rules.

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 1-800-851-3379.

We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive copayments and coinsurance.

- **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:

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.

(Primary payer chart begins on next page.)

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 the program.

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. You must use our providers.

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for your injuries

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

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. See page 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Custodial care means services designed to help beneficiaries meet the needs of daily living whether they are disabled or not. These services include help in: a) walking or getting in and out of bed; b) personal care such as bathing, dressing, eating or, preparing special diets; and/or c) taking medication that the beneficiary would normally be able to take without help. Custodial care that lasts 90 days or more is sometimes known as long-term care.
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 12.
Experimental or investigational services	The Plan considers factors which it determines to be most relevant under the circumstances, such as published reports and articles in the authoritative medical, scientific and peer review literature, or written protocols used by the treating facility or being used by another facility studying substantially the same drug, device or medical treatment. This Plan also considers federal and other government agency approval as essential to the treatment of an injury or illness by but not limited to the following: American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, the Food and Drug Administration or the National Institutes of Health.
Group health coverage	Any group arrangement that provides a member with hospital, medical, surgical or dental benefits and that consists of employer-sponsored group insurance, association sponsored group prepayment coverage, coverage under labor-management trustee plans, employer organization plans or employee benefit organizations.
Medical necessity	<p>A service or supply that is required to identify or treat a member's condition and is:</p> <ul style="list-style-type: none">• Appropriate and necessary for and consistent with the symptom or diagnosis and treatment or distinct improvement of an illness or injury; and• Adequate and essential for the evaluation or treatment of a disease, condition or illness; and• Can reasonably be expected to improve the member's condition or level of functioning; and• Conforms with standards of good medical practice, uniformly recognized and professionally endorsed by the general medical community at the time it is provided; and• Not mainly for the convenience of the member, a physician or other provider; and• The most appropriate medical service, supply or level of care that can safely be provided to the member as an outpatient.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance based on reasonable and customary charge. Preferred providers accept the Plan allowance as payment in full.
Us/We	Us and we refer to Health Alliance Medical Plans.
You	You refers to the enrollee and each covered family member.

Section 11 FEHB facts

Coverage Information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.
- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions and give you a *Guide to Federal Employees Health Benefits Plan* 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
 - When the next open season for enrollment begins

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

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

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

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

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.
- **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 Federal Employees Health Benefits (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 make any changes after retirement. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on 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 2006 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 2005 benefits until the effective date of your coverage under 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).

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under 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 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 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 have information about Federal and State agencies you can contact for more information.

Section 12 Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) 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. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

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. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return and who is mentally or physically incapable of self care.
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year.

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled during 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

- Online: visit www.fsafeds.com and click on **Enroll**.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

2006 Health Alliance HMO

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is

be able to answer your specific questions.

• **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

• **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. You must re-enroll every Open Season to remain in the paperless reimbursement program. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the

Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year plus a 2 ½ month grace period, resulting in the forfeiture of funds remaining in your account (the IRS "Use-it-or-Lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **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.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Accidental injury	40	Laboratory and pathological Services	16	Splints	30
Allergy tests	19	Machine diagnostic tests	16	Sterilization procedures	18
Alternative treatment	24	Magnetic Resonance Imaging (MRIs)	16	Subrogation	50
Allogeneic (donor) bone marrow transplant	27	Mail Order Prescription Drugs	36	Substance abuse	34
Ambulance	31	Mammograms	17	Surgery	25
Anesthesia	28	Maternity Benefits	18	Anesthesia	28
Autologous bone marrow transplant	27	Medicaid	50	Oral	26
B iopsies	25	Medically necessary	51	Outpatient	30
Blood and blood plasma	30	Medicare	46	Reconstructive	26
Breast cancer screening	17	Mental Conditions/Substance Abuse Benefits	34	Syringes	36
Casts	30	Neurological testing	16	Temporary continuation of coverage	54
Catastrophic protection out-of-pocket Maximum	12	Newborn care	18	Transplants	27
Changes for 2006	8	Non-FEHB Benefits	41	Treatment therapies	19
Chemotherapy.....	19	Nurse		Vision services	21
Childbirth	18	Licensed Practical Nurse	23	Well child care	17
Chiropractic	23	Nurse Anesthetist	28	Wheelchairs	22
Cholesterol tests.....	16	Nurse Practitioner	15	Workers' compensation	50
Claims	43	Psychiatric Nurse	34	X-rays	16
Coinsurance	12	Registered Nurse	23		
Colorectal cancer screening	16	Nursery charges	18		
Congenital anomalies.....	26	O bstetrical care	18		
Contraceptive devices and drugs	18	Occupational therapy	20		
Coordination of benefits	46	Ocular injury	21		
Covered charges	13	Office visits	15		
Covered providers	9	Oral and maxillofacial surgery	26		
Crutches	22	Orthopedic devices	22		
D eductible.....	12	Ostomy and catheter supplies	22		
Definitions	51	Out-of-pocket expenses	12		
Dental care	40	Outpatient facility care	30		
Diagnostic services	15	Oxygen	22		
Disputed claims review	44	P ap test	16		
Donor expenses (transplants).....	27	Physical examination	15		
Dressings	30	Physical therapy	20		
Durable medical equipment (DME)	22	Physician	15		
Educational classes and programs...	24	Pre-admission testing	30		
Effective date of enrollment	53	Precertification	10		
Emergency	32	Preventive care, adult	16		
Experimental or investigational	42	Preventive care, children	17		
Eyeglasses.....	21	Prescription drugs	36		
F amily planning	18	Preventive services	16		
Fecal occult blood test	16	Prior approval	10		
Fraud	3	Prostate cancer screening	16		
G eneral Exclusions	42	Prosthetic devices	22		
H earing services	21	Psychologist	34		
Home health services	23	Psychotherapy	34		
Hospice care	31	R adiation therapy	19		
Home nursing care	23	Renal dialysis	19		
Hospital	29	Room and board	29		
Immunizations	17	Second surgical opinion	15		
Infertility.....	19	Skilled nursing facility care	31		
In hospital physician care	15	Smoking cessation	24		
Inpatient Hospital Benefits	29	Speech therapy	21		
Insulin	37				

Summary of benefits for Health Alliance HMO 2006

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copayment: \$15 primary care, \$15 specialist	15
Services provided by a hospital: • Inpatient..... • Outpatient	\$250 copayment per admission \$100 per outpatient surgical admission	29 30
Emergency benefits: • In-area..... • Out-of-area	\$15 physician office/\$100 hospital ER \$15 physician office/\$100 hospital ER	33 33
Mental health and substance abuse treatment.....	Regular cost sharing	34
Prescription drugs	\$10/\$20/\$40	36
Dental Care	No benefit	40
Vision Care	\$15 copayment per exam	21
Special features: • Flexible benefits option		39
• Services for deaf and hearing impaired		
• Reciprocity benefits		
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$1,500/Self Only or \$3,000/Family enrollment per year Some costs do not count toward this protection The out-of-pocket maximum for Specialty Prescription Drugs is \$500 per member or \$1000 per family	12 12

2006 Rate Information for Health Alliance HMO

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

Type of Enrollment	Code	<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	FX1	\$139.18	\$ 58.49	\$301.56	\$126.73	\$164.31	\$ 33.36
Self & Family	FX2	\$316.08	\$145.26	\$684.84	\$314.73	\$373.15	\$ 88.19