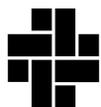


Health Alliance HMO

www.healthalliance.org



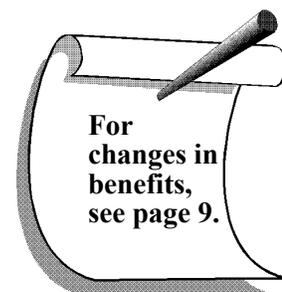
Health Alliance

2008

A Health Maintenance Organization (high and standard option) and a high deductible health plan

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 7 and 8 for requirements.



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

Enrollment codes for this Plan:

FX1 High Option Self Only

FX2 High Option Self and Family

FX4 Standard Option Self Only

FX5 Standard Option Self and Family

FM1 High Deductible Health Plan (HDHP) Self Only

FM2 High Deductible Health Plan (HDHP) 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>

RI 73-168

**Important Notice from Health Alliance Medical Plans, Inc. About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the Health Alliance HMO's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

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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, 2008, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them 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 United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

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

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanation of benefits (EOBs) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service or misrepresented any information, do the following
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 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:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (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.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Visit these web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. You can also view our provider directory at our Web site www.healthalliance.org. We give you the choice of enrollment in a High Option, a Standard Option or a High Deductible Health Plan.

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

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

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

General features of our High and Standard Options

The high and standard option plans offer coverage with no deductibles. You are responsible for a copayments and coinsurance.

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.

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.

- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$2,000 for Self Only enrollment, or \$4,000 family coverage for Preferred Providers and \$10,000 for Self Only enrollment or \$20,000 for family coverage for Non-Preferred Providers..

Your Rights

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

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.

Your medical and claims records are confidential

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

Service Area

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

Quincy Service Area: **Iowa Counties:** Lee

South Central Service Area: **Illinois Counties:** Clay, Crawford, Edwards, Hamilton, Jefferson, Lawrence, Madison, Marion, Richland, St. Clair, 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, Stephenson 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 our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2008

Do not rely only 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

- We are now offering a Standard Option Health Plan. This Plan is new to the FEHB Program.
- We are now offering a High Deductible Health Plan with HSA/HRA Option. This Plan is new to the FEHB Program.

Changes to High Option only

- Your share of the non-Postal premium will increase for the the Self Only and for the Self and Family plans.
- The Specialty Care office visit copayment increases to \$25 per visit.
- The hospital inpatient copayment is increased from \$250 to \$500 per hospital admission.
- The specialty pharmacy drug out-of-pocket benefit year allowable maximum increased to \$1500 for self and \$3000 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 letter (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 www.healthalliance.org.

Where you get covered care You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles and/or coinsurance, and you will not have to file claims. If you are enrolled in our High Deductible Health Plan, you can see Preferred Providers or Non-Preferred Providers, but you will pay higher copayments and coinsurance if you see Non-Preferred Providers.

- **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 some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex or serious medical condition, your Primary Care Physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your Primary Care Physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your Primary Care Physician. Your Primary Care Physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your Primary Care Physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

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

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

• **Hospital care**

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-851-3379. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

- You are discharged, not merely moved to 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 Physician 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 you are enrolled in the HDHP, you must preauthorize services received from an Non-Preferred Providers.

If the preauthorization request is approved, both you and your Primary Care Physician will be notified of the effective dates and the 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** For our High and Standard Option HMO plans, 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. For the High Deductible Health Plan we will cover non-emergent charges for Non-Preferred Providers, but you must receive preauthorization.
- 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 preauthorization 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 certain services.

Example: For the high option, 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 \$500 per admission.

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

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

- The calendar year deductible is \$2000 per person under the High Deductible Health Plan (HDHP) for Preferred Providers and \$4,000 per person under the HDHP for Non-Preferred Providers. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$4,000 under the HDHP for Preferred Providers and \$8,000 for Non-Preferred Providers.

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

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

Example: In our high and standard options, you pay 20% of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum

After your copayments and coinsurance totals \$1,500 per person or \$3,000 per family enrollment for the High Options and \$2,500 per person or \$5,000 per family for the Standard Option 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 \$1,500 per person or \$3,000 per family in the High and Standard Options. See Section 5(a) for specific information on coverage of specialty prescription drugs.

The out-of-pocket maximum for the High Deductible Health Plan (HDHP) Option is \$2,000 per person or \$4,000 per family to Preferred Providers and \$10,000 per person or \$20,000 per family for Non-Preferred Providers. 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

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.

When Government facilities bill us

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

High and Standard Option Benefits

See page 9 for how our benefits changed this year. Pages 104-105 are benefit summaries for each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High and Standard Option benefits, contact us at 1-800-851-3379 or at our Web site at www.healthalliance.org.

Each option offers unique features.

- **High Option**

The High Option offers the most comprehensive benefits. Our High Option benefits include:

- \$15 per office visit to a Primary Care Physician.
- \$25 per office visit to a Specialist.
- \$500 per inpatient admission.
- \$100 per outpatient surgical admission.
- \$100 per emergency room visit.
- \$10/\$20/\$40 copayments on Tiers 1, 2 or 3 for a 30 day supply of prescription drugs.

- **Standard Option**

We also offer a Standard Option. With the Standard Option your copayments and coinsurance may be higher than with the High Option, but it will cost you less in premiums. Our Standard Option benefits include:

- \$20 per office visit to a Primary Care Physician.
- \$35 per office visit to a Specialist.
- 20% coinsurance per inpatient admission.
- 20% coinsurance for outpatient hospital Services.
- \$150 per emergency room visit.
- \$20/\$35/\$50 copayments on Tiers 1, 2 or 3 for a 30 day supply of prescription drugs.

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.
- A 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	
	High Option	Standard Option
Diagnostic and treatment services		
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$15 per office visit to a Primary Care Physician. \$25 per office visit to a Specialist.	\$20 per office visit to a Primary Care Physician. \$35 per office visit to a Specialist.
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • Office medical consultation • Second surgical opinion 	\$15 per office visit to a Primary Care Physician. \$25 per office visit to a Specialist.	\$20 per office visit to a Primary Care Physician. \$35 per office visit to a Specialist.
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.	20% coinsurance.
At home	\$25 per visit.	\$35 per visit.
Lab, X-ray and other diagnostic tests		
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing. You pay only your office visit copayment.	Nothing. You pay only your office visit copayment.

Benefit Description	You pay	
	High Option	Standard Option
Preventive care, adult		
Routine physical every year which includes: Routine screenings, such as: <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 enema – every five years starting at age 50 	\$15 per office visit to a Primary Care Physician. \$25 per office visit to a Specialist.	\$20 per office visit to a Primary Care Physician. \$35 per office visit to a Specialist.
<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 	\$100 copayment per outpatient surgical admission when the service is provided in an outpatient hospital setting or outpatient surgical facility.	20% coinsurance per outpatient surgical admission when the service is provided in an outpatient hospital setting or outpatient surgical facility.
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing. You pay only your office visit copayment.	Nothing. You pay only your office visit copayment.
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> .	Nothing. You pay only your office visit copayment.	Nothing. You pay only your office visit copayment.
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 office visit copayment.	Nothing. You pay only your office visit copayment.
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC).	Nothing. You pay only your office visit copayment.	Nothing. You pay only your office visit copayment.
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</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 office visit copayment.	Nothing. You pay only your 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 	\$15 per office visit to a Primary Care Physician. \$25 per office visit to a Specialist.	\$20 per office visit to a Primary Care Physician. \$35 per office visit to a Specialist.

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) 	<p>\$15 per office visit to a Primary Care Physician.</p> <p>\$25 per office visit to a Specialist.</p>	<p>\$20 per office visit to a Primary Care Physician.</p> <p>\$35 per office visit to a Specialist.</p>
Maternity care	High Option	Standard Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 12 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 5c) and Surgery benefits (Section 5b). 	<p>\$50 copayment per pregnancy. Care provided by specialists during prenatal period is subject of the \$25 office visit copayment.</p>	<p>20% coinsurance.</p> <p>Care provided by specialists during the prenatal period is subject to the \$35 office visit copayment.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Routine sonograms to determine fetal age, sex or size</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Family planning	High Option	Standard Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>Nothing. You pay only your office visit copayment.</p>	<p>Nothing. You pay only your office visit copayment.</p>

Benefit Description	You pay	
Family planning (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<i>All charges.</i>	<i>All charges.</i>
Infertility services	High Option	Standard Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • 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 injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	<p>\$15 per office visit to a Primary Care Physician.</p> <p>\$25 per office visit to a Specialist.</p>	<p>\$20 per office visit to a Primary Care Physician.</p> <p>\$35 per office visit to a Specialist.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>ART procedures not listed in the section above</i> • <i>Non-medical cost of donor sperm</i> • <i>Non-medical cost of donor egg</i> • <i>Infertility service after voluntary sterilization</i> 	<i>All charges.</i>	<i>All charges.</i>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$15 per office visit to a Primary Care Physician.</p> <p>\$25 per office visit to a Specialist.</p>	<p>\$20 per office visit to a Primary Care Physician.</p> <p>\$35 per office visit to a Specialist.</p>
Allergy serum	Nothing.	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing and sublingual allergy desensitization</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 30.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) 	<p>\$15 per office visit to a Primary Care Physician.</p> <p>\$25 per office visit to a Specialist.</p> <p>Nothing per visit during a covered inpatient admission.</p>	<p>\$20 per office visit to a Primary Care Physician.</p> <p>\$35 per office visit to a Specialist.</p> <p>20% coinsurance per covered inpatient admission.</p>
Specialty Pharmacy Drugs	High Option	Standard Option
<ul style="list-style-type: none"> • Specialty Pharmacy Drugs <p>Some Specialty Pharmacy 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 Pharmacy Drugs and the medical conditions for which they are approved for coverage. Examples of Specialty Pharmacy Drugs include: Interferons, Erythropoietin and granulocyte colony stimulating factor (G-CSF). Specialty Pharmacy Drugs must be purchased through Walgreens, either through the mail or local retail store, and are limited to a 30-day supply. Coverage can be verified by calling the Health Alliance 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>\$1,500 per member \$3,000 per family</p>	<p>20% Coinsurance.</p> <p>Out-of-pocket maximum, per calendar year:</p> <p>\$1,500 per member \$3,000 per family</p>

Benefit Description	You pay	
Physical and occupational therapies	High Option	Standard Option
<p>A combined total of 60 visits per condition per calendar year for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <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 pages 34-36.</p> <p>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>	<p>\$15 per office visit.</p> <p>\$15 per outpatient visit.</p> <p>Nothing per visit during covered inpatient admission.</p>	<p>\$20 per office visit.</p> <p>\$20 per outpatient visit.</p> <p>20% coinsurance per covered inpatient admission.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs • Phase III cardiac rehabilitation 	<i>All charges.</i>	<i>All charges.</i>
Speech therapy	High Option	Standard Option
<ul style="list-style-type: none"> • 60 visits per condition per calendar year 	<p>\$15 per office visit.</p> <p>\$15 per outpatient visit.</p> <p>Nothing per visit during covered inpatient admission.</p>	<p>\$20 per office visit.</p> <p>\$20 per outpatient visit.</p> <p>20% coinsurance per covered inpatient admission.</p>
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing screenings and evaluations <p>Note: See <i>Preventive care, children</i> for hearing screenings for children</p>	<p>\$15 per office visit to a Primary Care Physician.</p> <p>\$25 per office visit to a Specialist.</p>	<p>\$20 per office visit to a Primary Care Physician.</p> <p>\$35 per office visit to a Specialist.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Hearing aids, testing and examinations for them, except as stated above 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<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) • Annual eye refractions <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	<p>\$15 per office visit to a Primary Care Physician.</p> <p>\$25 per office visit to a Specialist.</p>	<p>\$20 per office visit to a Primary Care Physician.</p> <p>\$35 per office visit to a Specialist.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, except as shown above</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Foot care	High Option	Standard Option
<ul style="list-style-type: none"> • Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. <p>See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts</p>	<p>\$15 per office visit to a Primary Care Physician.</p> <p>\$25 per office visit to a Specialist.</p>	<p>\$20 per office visit to a Primary Care Physician.</p> <p>\$35 per office visit to a Specialist.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • 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 Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Foot orthotics • Lumbosacral supports 	<p>20% coinsurance.</p>	<p>20% coinsurance.</p>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Orthopedic and corrective shoes (except for diabetic shoes when medical criteria is met) • Arch supports • Heel pads and heel cups • Prosthetic replacements provided less than five years after the last one we covered, unless it is irreparable and the member has properly maintained it. 	<i>All charges.</i>	<i>All charges.</i>
Durable medical equipment (DME)	High Option	Standard Option
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors • 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.	20% coinsurance.
Home health services	High Option	Standard Option
<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 visit.	\$20 per visit.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient's family • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
Chiropractic	High Option	Standard Option
<ul style="list-style-type: none"> • Manipulation of the spine and extremities 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.	\$20 per office visit.
Alternative treatments	High Option	Standard Option
<ul style="list-style-type: none"> • Biofeedback - under certain circumstance 	\$15 per office visit to a Primary Care Physician. \$25 per office visit to a Specialist.	\$20 per office visit to a Primary Care Physician. \$35 per office visit to a Specialist.
<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>	<i>All charges.</i>
Educational classes and programs	High Option	Standard Option
Coverage is limited to: <ul style="list-style-type: none"> • Diabetes self management 	\$15 per office visit to a Primary Care Physician. \$25 per office visit to a Specialist.	\$20 per office visit to a Primary Care Physician. \$35 per office visit to a Specialist.
<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. 	All charges over the \$100 smoking cessation benefit. Option of purchasing up to two months of nicotine replacement therapy (requires a prescription), prescription Chantix ® or prescription Zyban ® for a \$15/month copayment at Plan pharmacies through the <i>I Can Quit</i> program.	All charges over the \$100 smoking cessation benefit. Option of purchasing up to two months of nicotine replacement therapy (requires a prescription), prescription Chantix ® or prescription Zyban ® for a \$15/month copayment at Plan pharmacies through the <i>I Can Quit</i> program.

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • 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, Chantix ® 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), prescription Chantix ® or prescription Zyban ® for a \$15/month copayment at Plan pharmacies through the <i>I Can Quit</i> program.</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), prescription Chantix ® 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 FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.

Benefit Description	You pay	
	High Option	Standard Option
<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 <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery). See <i>Services requiring our approval</i> on page 12. • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation) (vasectomy only covered in a 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 Surgery benefits for insertion of the pacemaker.</p>	<p>\$15 per office visit to a Primary Care Physician.</p> <p>\$25 per office visit to a Specialist.</p> <p>Nothing if you are an inpatient in a hospital. You pay only your hospital admission copayment.</p> <p>Nothing if performed in an outpatient hospital setting or ambulatory surgical facility. You pay only your outpatient surgical facility copayment.</p>	<p>\$20 per office visit to a Primary Care Physician.</p> <p>\$35 per office visit to a Specialist.</p> <p>20% coinsurance if you are inpatient or outpatient in a hospital or at an ambulatory surgical facility.</p>

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	High Option	Standard Option
<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>	<p><i>All charges.</i></p>
Reconstructive surgery	High Option	Standard Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect. • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities, cleft lip, cleft palate, birth marks, webbed fingers and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <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 to a Primary Care Physician.</p> <p>\$25 per office visit to a Specialist.</p> <p>Nothing if you are an inpatient in a hospital. You pay only your hospital admission copayment.</p> <p>Nothing if performed in an outpatient hospital setting or ambulatory surgical facility. You pay only your outpatient surgical facility copayment.</p>	<p>\$20 per office visit to a Primary Care Physician.</p> <p>\$35 per office visit to a Specialist.</p> <p>20% coinsurance if you are inpatient or outpatient in a hospital or at an ambulatory surgical facility.</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>	<p><i>All charges.</i></p>

Benefit Description	You pay	
	High Option	Standard Option
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 to a Primary Care Physician.</p> <p>\$25 per office visit to a Specialist.</p> <p>Nothing if you are an inpatient in a hospital. You pay only your hospital admission copayment.</p> <p>Nothing if performed in an outpatient hospital setting or ambulatory surgical facility. You pay only your outpatient surgical facility copayment.</p>	<p>\$20 per office visit to a Primary Care Physician.</p> <p>\$35 per office visit to a Specialist.</p> <p>20% coinsurance if you are inpatient or outpatient in a hospital or at an ambulatory surgical facility.</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> 	<i>All charges.</i>	<i>All charges.</i>
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ transplants are subject to medical necessity and experimental/ investigational review. Refer to <i>Other services</i> in Section 3 for preauthorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure.</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Lung: single - double • Kidney • Liver • Pancreas • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas 	Nothing.	20% coinsurance.
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia 	Nothing.	20% coinsurance.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplant for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	Nothing.	20% coinsurance.
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, Mediastinal, Retroperitoneal and Ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer 	Nothing.	20% coinsurance.
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma 	Nothing.	20% coinsurance.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Breast Cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon Cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas • Autologous transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing.	20% coinsurance.
<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>	Please contact Health Alliance at 1-800-851-3379 for the current per diem reimbursement rates.	Please contact Health Alliance at 1-800-851-3379 for the current per diem reimbursement rates.
<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> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
Anesthesia	High Option	Standard Option
Professional services provided in – • Hospital (inpatient)	Nothing. You pay only your hospital admission copayment.	20% coinsurance.
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing if you are a patient in an outpatient hospital setting or ambulatory surgical facility. You pay only your outpatient surgical facility copayment.	20% coinsurance.
Professional services provided in - • Office	Nothing. You pay only your office visit copayment.	20% coinsurance.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You pay	
	High Option	Standard Option
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 diet. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$500 per admission.	20% coinsurance.
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • 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.	20% coinsurance.
<i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes and schools 	<i>All charges.</i>	<i>All charges.</i>

Inpatient hospital - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Inpatient hospital (cont.)		
<ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges.</i>	<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 copayment per outpatient surgical admission.	20% coinsurance.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Blood and blood derivatives not replaced by the member</i> 	<i>All charges.</i>	<i>All charges.</i>
Extended care benefits/skilled nursing care facility benefits/rehabilitative services		
<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 120 days per calendar year.</p>	Nothing.	20% coinsurance.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> 	<i>All charges.</i>	<i>All charges.</i>
Hospice care		
<p>Supportive and palliative care for terminally ill members 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.	20% coinsurance.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing, homemaker services</i> 	<i>All charges.</i>	<i>All charges.</i>

High and Standard Option

Benefit Description	You pay	
Ambulance	High Option	Standard Option
Local professional ambulance service when medically appropriate	Nothing.	20% coinsurance.

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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, 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.

High and Standard Option

Benefit Description	You pay	
Emergency within our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital , including doctors’ services <p>Note: If admitted, the emergency room copayment is waived and you pay the appropriate inpatient hospital admission copayment.</p>	<p>\$15 per office visit.</p> <p>\$15 per office visit.</p> <p>\$100 per emergency room visit.</p>	<p>\$20 per office visit.</p> <p>\$20 per office visit.</p> <p>\$150 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>All charges.</i>	<i>All charges.</i>
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$15 per office visit.</p> <p>\$15 per office visit.</p> <p>\$100 per emergency room visit.</p>	<p>\$20 per office visit.</p> <p>\$20 per office visit.</p> <p>\$150 per emergency room visit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges.</i>	<i>All charges.</i>
Ambulance	High Option	Standard Option
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	Nothing.	20% coinsurance.

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 FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay	
	High Option	Standard Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<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>	<p>\$20 per visit.</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing.</p>	<p>20% coinsurance.</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization or facility based intensive outpatient treatment 	<p>\$500 per admission.</p>	<p>20% coinsurance.</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization 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.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy or by mail order. For members who take maintenance medication, you have three choices. Mail order prescriptions and **Choice 90Rx are optional and available only to members who take maintenance medication.**
 - Choice 1: Get a 30-day supply of medications for one copayment at a local retail pharmacy. This is the same benefit available for one-time prescriptions.
 - Choice 2: Get 90 days of maintenance medication through mail order and receive a discount.
 - Choice 3: Get 90 days of maintenance medication a local retail pharmacy and also receive a discount. You must take a prescription for a 90-day supply to a participating Choice90Rx pharmacy or have your prescription transferred to a Choice 90Rx pharmacy.
- **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 referring physician and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. Maintenance medication can be dispensed for up to a 90-day supply through mail order or at a pharmacy participating in Choice 90Rx.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs 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 do 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.

Benefit Description	You pay	
Covered medications and supplies	High Option	Standard Option
<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 referring physician and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply or manufacturer’s standard package. • For members who take maintenance medication and choose the options of mail order or Choice 90Rx at a participating pharmacy for a 90-day supply, you pay 2.75 copayments. • 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 <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.</p> <p>\$20 Tier 2.</p> <p>\$40 Tier 3</p> <p>For members on maintenance medication that choose to use the options of mail order or Choice 90Rx, per 90 day supply:</p> <p>\$27.50 Tier 1.</p> <p>\$55 Tier 2.</p> <p>\$110 Tier 3.</p> <p>Mail order and Choice 90Rx copayments are based upon a 90-day supply. You pay 2.75 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> <p>Note: 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.</p>	<p>At a Plan Pharmacy:</p> <p>\$20 Tier 1.</p> <p>\$35 Tier 2.</p> <p>\$50 Tier 3.</p> <p>For members on maintenance medication that choose to use the options of mail order or Choice 90Rx, per 90 day supply:</p> <p>\$55 Tier 1.</p> <p>\$96.25 Tier 2.</p> <p>\$137.50 Tier 3.</p> <p>Mail order and Choice 90Rx copayments are based upon a 90-day supply. You pay 2.75 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> <p>Note: 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 \$20 plus the difference in the cost between the generic and the brand-name drug. If the physician does not allow substitutions, the member will pay the \$35 copayment.</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>First Month Free</i> – First Month Free allows for a free 30-day trial of any Tier 1 maintenance medication. Antibiotics, pain medications or short-term/periodic medication are not included. 	Nothing.	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Drugs for which there is a non-prescription equivalent available</i> • <i>Medical supplies, such as dressings & antiseptics</i> 	<i>All charges.</i>	<i>All charges.</i>

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Accidental injury benefit	High Option	Standard Option
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.	Nothing.

Dental benefits

We have no other dental benefits.

Section 5(h). 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 less costly alternative benefits • 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	<p>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.</p>

High Deductible Health Plan Benefits

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Section 5. High Deductible Health Plan Benefits Overview

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

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 1-800-851-3379 or at our Web site at www.healthalliance.org.

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

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

With this plan, the member is responsible for a \$25 copayment at a Preferred Provider for routine physical exams (adult and children). Other preventative care services, routine screenings, routine adult and childhood immunizations, well-child visits, vision and hearing exams through age 17, are paid at 100% at a Preferred Provider.

As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 58. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

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

- **Preventive Care**

The Plan covers plan covers routine screenings such as blood tests, cholesterol screening, urinalysis, PSA test and colorectal cancer screenings. These services are covered at 100% when you use a Preferred Provider and at 50% when you use a Non-Preferred Provider.

There is a \$25 copayment for annual routine physical exams at a Preferred Provider and 50% coinsurance when you use a Non-Preferred Provider. *You do not have to meet the deductible before using these services.*
- **Traditional medical coverage**

After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 100% for in-network and 50% for out-of-network care.

Covered services include:

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

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

Health Savings Accounts (HSA)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else’s tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2008, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$83.33 per month for a Self Only enrollment or \$166.67 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$2,900 for an individual and \$5,800 for a family. See maximum contribution information on page 51. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

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

HSA features include:

- Your HSA is administered by BPC, Inc., 2110 Clearlake Blvd, Ste 200, Champaign, IL 61822
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It’s portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available.

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

Health Reimbursement Arrangements (HRA)

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

In 2008, we will give you an HRA credit of \$1,000 per year for a Self Only enrollment and \$2,000 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don’t count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by BPC, Inc., 2110 Clearlake Blvd, Ste 200, Champaign, IL 61822
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.

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

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

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$2,000 per person or \$4,000 per family enrollment for Preferred Providers and \$10,000 per person or \$20,000 per family for Non-Preferred Providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

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

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

Section 5. Savings - HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with HSA Bank, this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.) BPC, Inc, is the adminrator for your HSA.	HSA Bank is the HRA fiduciary for this Plan. BPC, Inc, is the administrator for your HRA.
Fees	Set-up fee is paid by the HDHP.	None.
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else’s tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork 	<p>You must enroll in this HDHP.</p> <p>Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.</p>
Funding	<p>If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.</p> <p>In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).</p>	<p>Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.</p>
<ul style="list-style-type: none"> • Self Only enrollment 	For 2008, a monthly premium pass through of \$83.33 will be made by the HDHP directly into your HSA each month.	For 2008, your HRA annual credit is \$1,000 (prorated for mid-year enrollment).
<ul style="list-style-type: none"> • Self and Family enrollment 	For 2008, a monthly premium pass through of \$166.67 will be made by the HDHP directly into your HSA each month.	For 2008, your HRA annual credit is \$2,000 (prorated for mid-year enrollment).
Contribution/credits		The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	<p>The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of \$2,900 for an individual and \$5,800 for a family.</p> <p>If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.</p> <p>You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.</p> <p>If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death and disability.</p> <p>You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP).</p> <p>HSAs earn tax-free interest (does not affect your annual maximum contribution).</p> <p>Catch-up contribution discussed on page 54.</p>	
<ul style="list-style-type: none"> • Self Only enrollment 	<p>See above.</p>	<p>You cannot contribute to the HRA.</p>
<ul style="list-style-type: none"> • Self and Family enrollment 	<p>See above.</p>	<p>You cannot contribute to the HRA.</p>
<p>Access funds</p>	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> • Debit card • Withdrawal form • Checks 	<p>For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.</p>

<p>Distributions/withdrawals</p> <ul style="list-style-type: none"> • Medical 	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>
<ul style="list-style-type: none"> • Non-medical 	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.</p>
<p>Availability of funds</p>	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you. 	<p>The entire amount of your HRA will be available to you upon your enrollment in the HDHP.</p>
<p>Account owner</p>	<p>FEHB enrollee</p>	<p>HDHP</p>
<p>Portable</p>	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 51 for HSA eligibility.</p>	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p>

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

If you have an HSA

- **Contributions**

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

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

- **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. In 2008, you may contribute up to \$900 in catch-up contributions. The allowable catch-up contribution will be \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.

- **If you die**

If you do not have a named beneficiary, if you are married, it becomes your spouse’s HSA; otherwise, it becomes part of your taxable estate.

- **Qualified Expenses**

You can pay for “qualified medical expenses,” as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

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

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

- **Non-qualified expenses** You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- **Tracking your HSA balance** You will receive a periodic statement that shows the “premium pass through”, withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.
- **Minimum reimbursements from your HSA** You can request reimbursement in any amount.

If you have an HRA

- **Why an HRA is established** If you don’t qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.
- **How an HRA differs** Please review the chart on pages 51-54 which details the differences between an HRA and an HSA. The major differences are:
 - You cannot make contributions to an HRA
 - Funds are forfeited if you leave the HDHP
 - An HRA does not earn interest, and
 - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Section 5. Preventative care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible. You only owe your copayments or coinsurance for covered preventive care services.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*

Benefit Description	You Pay	
	Preferred Provider	Non-Preferred Provider
Preventative care, adult Routine screenings, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test yearly starting at age 50, - Sigmoidoscopy screening — every five years starting at age 50, - Double contrast barium enema — every five years starting at age 50; - Colonoscopy screening — every 10 years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older • 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 	\$0 Copayment (Deductible does not apply)	50% Coinsurance (Deductible does not apply)
<ul style="list-style-type: none"> • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) 	\$0 Copayment (Deductible does not apply)	50% Coinsurance (Deductible does not apply)
<ul style="list-style-type: none"> • Routine physicals which include: <ul style="list-style-type: none"> - One exam every 24 months up to age 65 - One exam every 12 months age 65 and older • Routine exams limited to: <ul style="list-style-type: none"> - 1 routine eye exam every 12 months - 1 routine OB/GYN exam every 12 months including 1 Pap smear and related services - 1 routine hearing exam every 24 months 	\$25 Copayment (Deductible does not apply)	50% coinsurance (Deductible does not apply)
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>

Preventative care, adult - continued on next page

Benefit Description	You Pay	
Preventative care, adult (cont.)	Preferred Provider	Non-Preferred Provider
<ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<i>All charges.</i>	<i>All charges.</i>
Preventative care, children	Preferred Provider	Non-Preferred Provider
<ul style="list-style-type: none"> • Professional services, such as: • Well-child visits for routine examinations, immunizations and care (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: • Eye exam through age 17 to determine the need for vision correction • Hearing exams through age 17 to determine the need for hearing correction 	\$0 Copayment (Deductible does not apply)	50% coinsurance (Deductible does not apply)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> • <i>Immunizations, boosters, and medications for travel.</i> 	<i>All charges.</i>	<i>All charges.</i>

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Preventive care received at a Preferred Provider is covered at 100% (see pages 56 and 57), except for routine physicals which have a \$25 copayment, and is not subject to the calendar year deductible. Preventative care at Non-Preferred Providers is covered at 50% and is not subject to the calendar year deductible.
- The deductible is \$2,000 per person or \$4,000 per family enrollment for Preferred Providers and \$4,000 per person or \$8,000 per family enrollment for Non-Preferred Providers. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- You are protected by an annual catastrophic maximum on out-of-pocket expenses for most covered services. After your coinsurance, copayments and deductibles total \$2,000 per person or \$4,000 per family enrollment for Preferred Providers and \$10,000 per person or \$20,000 per family enrollment for Non-Preferred Providers in any calendar year, you do not have to pay any more for covered services. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit maximum, or if you use Non-Preferred Providers, amounts in excess of the Plan allowance).
- Preferred Provider benefits apply only when you use a Preferred Provider. When a Preferred Provider is not available, Non-Preferred Provider benefits apply.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the You pay column, we say “No deductible” when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$2,000 per person or \$4,000 per family enrollment for Preferred Providers and \$4,000 per person or \$8,000 per family for Non-Preferred Providers.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	<p>In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket.</p> <p>Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.</p>

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.
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment for Preferred Providers or \$4,000 for Self Only enrollment and \$8,000 for Self and Family enrollment for Non-Preferred Providers each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay After the calendar year deductible	
Diagnostic and treatment services	Preferred Provider	Non-Preferred Provider
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion 	\$0 Copayment for Primary Care Physician office visit. \$0 Copayment for Specialist office visit.	50% Coinsurance for Primary Care Physician office visit 50% Coinsurance for Specialist office visit.
Lab, X-ray and other diagnostic tests	Preferred Provider	Non-Preferred Provider
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	\$0 Copayment	50% Coinsurance

Benefit Description	You Pay After the calendar year deductible	
	Preferred Provider	Non-Preferred Provider
<p>Maternity Care</p> <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 precertify your normal delivery; see page 12 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. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5c) and <i>Surgery benefits</i> (Section 5b). 	\$0 Copayment.	50% Coinsurance.
<p>Family planning</p> <p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	\$0 copayment.	50% coinsurance (does not apply to Plan Year Out-of-Pocket Maximum).
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization.</i> • <i>Genetic counseling.</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You Pay After the calendar year deductible	
	Preferred Provider	Non-Preferred Provider
Infertility Services		
<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>	\$0 copayment.	50% coinsurance (does not apply to Plan Year Out-of-Pocket Maximum).
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>ART procedures not listed in the section above</i> • <i>Non-medical cost of donor sperm</i> • <i>Non-medical cost of donor egg</i> • <i>Infertility service after voluntary sterilization</i> 	<i>All charges</i>	<i>All charges</i>
Allergy care	Preferred Provider	Non-Preferred Provider
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	\$0 copayment.	50% coinsurance.
Allergy serum	\$0 copayment.	50% coinsurance.
Treatment therapies	Preferred Provider	Non-Preferred Provider
<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 pages 68 through 70.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	0% coinsurance.	50% coinsurance.

Treatment therapies - continued on next page

Benefit Description	You Pay After the calendar year deductible	
	Preferred Provider	Non-Preferred Provider
<p>Treatment therapies (cont.)</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. Specialty Pharmacy Drugs <p>Some Specialty Pharmacy 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 Pharmacy Drugs and the medical conditions for which they are approved for coverage. Examples of Specialty Pharmacy Drugs include: Interferons, Erythropoietin and granulocyte colony stimulating factor (G-CSF). Specialty Pharmacy Drugs must be purchased through Walgreens, either through the mail or local retail store, and are limited to a 30-day supply. Coverage can be verified by calling the Health Alliance Customer Service Department at 1-800-851-3379.</p>	0% coinsurance.	50% coinsurance.
<p>Physical and occupational therapies</p> <p>A combined total of 60 visits per condition for the services of each of the following:</p> <ul style="list-style-type: none"> qualified physical therapists and occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 24 sessions in 12 consecutive weeks or less for Phase II. Phase I cardiac rehab is provided in the hospital after surgery. 	\$0 Copayment.	50% coinsurance.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Long-term rehabilitative therapy</i> <i>Exercise programs</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You Pay After the calendar year deductible	
	Preferred Provider	Non-Preferred Provider
Speech therapy		
A combined total of 60 visits per condition per plan year for Inpatient (includes skilled nursing) and Outpatient Speech Therapy	\$0 Copayment.	50% Coinsurance.
Hearing services (testing, treatment and supplies)		
<ul style="list-style-type: none"> First hearing aid and testing only when necessitated by accidental injury 	\$0 Copayment.	50% coinsurance (does not apply to Plan Year Out-of-Pocket Maximum).
<ul style="list-style-type: none"> Hearing exams for children through age 17 (see <i>Preventative care, children</i>) 	\$0 copayment (Deductible does not apply.)	50% coinsurance. (Deductible does not apply.)
<i>Not covered:</i> <ul style="list-style-type: none"> All other hearing testing Hearing aids, testing and examinations for them 	<i>All charges.</i>	<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) Annual eye refractions 	\$0 Copayment.	50% Coinsurance (does not apply to Plan Year Out-of-Pocket Maximum).
<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>	<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.	\$0 Copayment.	50%Coinsurance.
<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 or 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>	<i>All charges.</i>

Benefit Description	You Pay After the calendar year deductible	
	Preferred Provider	Non-Preferred Provider
<p>Orthopedic and prosthetic devices</p> <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. Note: See 5(b) for coverage of the surgery to insert the device. 	0% Coinsurance.	50% Coinsurance (does not apply to Plan Year Out-of-Pocket Maximum).
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Orthopedic and corrective shoes</i> <i>Arch supports</i> <i>Foot orthotics</i> <i>Heel pads and heel cups</i> <i>Lumbosacral supports</i> <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> <i>Prosthetic replacements provided less than {X} years after the last one we covered</i> 	<i>All charges.</i>	<i>All charges.</i>
<p>Durable medical equipment</p> <p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> Oxygen; Dialysis equipment; Hospital beds; Wheelchairs; Crutches; Walkers; Blood glucose monitors; and Insulin pumps. <p>Note: Call us at 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>	0% Coinsurance.	50% Coinsurance (does not apply to Plan Year Out-of-Pocket Maximum).

Benefit Description	You Pay After the calendar year deductible	
	Preferred Provider	Non-Preferred Provider
Home health services		
<ul style="list-style-type: none"> Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Services include oxygen therapy, intravenous therapy and medications. 	0% Coinsurance.	50% Coinsurance (does not apply to Plan Year Out-of-Pocket Maximum).
<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>	<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>	\$0 Copayment. \$500 combined Preferred and Non-Preferred Provider Plan Year Maximum Benefit.	50% Coinsurance. \$500 combined Preferred and Non-Preferred Provider Plan Year Maximum Benefit. Does not apply to Plan Year Out-of-Pocket Maximum
Alternative treatments		
Biofeedback – under certain circumstances	\$0 Copayment.	50% Coinsurance.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Naturopathic services</i> <i>Hypnotherapy</i> <i>Accupuncture</i> 	<i>All charges.</i>	<i>All charges.</i>
Educational classes and programs		
Coverage is limited to: <ul style="list-style-type: none"> Diabetes self management 	\$0 Copayment.	50% Coinsurance.
<ul style="list-style-type: none"> Smoking Cessation 	0% Coinsurance.	50% Coinsurance.

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.
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment for Preferred Providers and \$4,000 for Self Only enrollment and \$8,000 for Self and Family enrollment for Non-Preferred Providers each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible...	
	Preferred Provider	Non-Preferred Provider
Surgical procedures		
A comprehensive range of services, such as:	0% Coinsurance.	50% Coinsurance.
<ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) if medical criteria determined by the plan are met (See <i>Services requiring our approval</i> on Page 12.) • Insertion of internal prosthetic devices . See 5(a) <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns 		

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	Preferred Provider	Non-Preferred Provider
Surgical procedures (cont.)		
Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	0% Coinsurance.	50% Coinsurance.
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>
<ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 		
Reconstructive surgery	Preferred Provider	Non-Preferred Provider
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	0% Coinsurance.	50% Coinsurance.
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>
<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> 		

Benefit Description	You pay After the calendar year deductible...	
	Preferred Provider	Non-Preferred Provider
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 	0% Coinsurance.	50% Coinsurance.
<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> 	<i>All charges.</i>	<i>All charges.</i>
Organ/tissue transplants		
<p>Solid organ transplants are subject to medical necessity and experimental/ investigational review. Refer to <i>Other services</i> in Section 3 for preauthorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure.</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Lung: single – double • Kidney • Liver • Pancreas • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas 	<p>0% Coinsurance.</p> <p>Transplants are covered when performed at a Health Alliance approved facility.</p>	Not covered.
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnosis</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma 	<p>0% Coinsurance.</p> <p>Transplants are covered when performed at a Health Alliance approved facility.</p>	Not covered.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	Preferred Provider	Non-Preferred Provider
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	<p>0% Coinsurance.</p> <p>Transplants are covered when performed at a Health Alliance approved facility.</p>	<p>Not covered.</p>
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, Mediastinal, Retroperitoneal and Ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer 	<p>0% Coinsurance.</p> <p>Transplants are covered when performed at a Health Alliance approved facility.</p>	<p>Not covered.</p>
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Breast Cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon Cancer 	<p>0% Coinsurance.</p> <p>Transplants are covered when performed at a Health Alliance approved facility.</p>	<p>Not covered.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	Preferred Provider	Non-Preferred Provider
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas • Autologous transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>0% Coinsurance.</p> <p>Transplants are covered when performed at a Health Alliance approved facility.</p>	<p>Not covered.</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>0% Coinsurance.</p> <p>Transplants are covered when performed at a Health Alliance approved facility.</p>	<p>Not covered.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered • Experimental organ or tissue transplants 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Anesthesia	Preferred Provider	Non-Preferred Provider
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	<p>0% Coinsurance.</p>	<p>50% Coinsurance.</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	<p>0% Coinsurance.</p>	<p>50% Coinsurance.</p>

Anesthesia - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Anesthesia (cont.)	Preferred Provider	Non-Preferred Provider
• Office	0% Coinsurance.	50% Coinsurance.

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 .
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment for Preferred Providers and \$4,000 for Self only and \$8,000 for Self and Family for Non-Preferred Providers each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
	Preferred Provider	Non-Preferred Provider
Inpatient hospital Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	0% Coinsurance.	50% Coinsurance.
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) 	0% Coinsurance.	50% Coinsurance.
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>

Inpatient hospital - continued on next page
 HDHP Section 5(c)

Benefit Description	You pay	
	Preferred Provider	Non-Preferred Provider
Inpatient hospital (cont.)		
<ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	<i>All charges.</i>	<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 • 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>	0% Coinsurance.	50% Coinsurance.
<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>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits/Rehabilitation services		
<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>	0% Coinsurance.	50% Coinsurance.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care 	<i>All charges.</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>	0% Coinsurance.	50% Coinsurance.
<p><i>Not covered:</i></p>	<i>All charges.</i>	<i>All charges.</i>

Hospice care - continued on next page

Benefit Description	You pay	
Hospice care (cont.)	Preferred Provider	Non-Preferred Provider
• <i>Independent nursing, homemaker services</i>	<i>All charges.</i>	<i>All charges.</i>
Ambulance	Preferred Provider	Non-Preferred Provider
Local professional ambulance service when medically appropriate	0% Coinsurance.	0% Coinsurance.

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment for Preferred Providers and \$4,000 for Self Only enrollment and \$8,000 for Self and Family enrollment for Non-Preferred Providers each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency

Emergencies within our service area: If you are in an emergency situation, 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	
	Preferred Provider	Non-Preferred Provider
Emergency within our service area	Preferred Provider	Non-Preferred Provider
<ul style="list-style-type: none"> Emergency care at a doctor’s office Emergency care at an urgent care center Emergency care as an outpatient in a hospital, including doctors’ services 	0% Coinsurance.	0% Coinsurance.
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>	<i>All charges.</i>
Emergency outside our service area	Preferred Provider	Non-Preferred Provider
<ul style="list-style-type: none"> Emergency care at a doctor’s office Emergency care at an urgent care center Emergency care as an outpatient in a hospital, including doctors’ services 	0% Coinsurance.	0% Coinsurance.
<i>Not covered:</i> <ul style="list-style-type: none"> <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges.</i>	<i>All charges.</i>
Ambulance	Preferred Provider	Non-Preferred Provider
Professional ambulance service when medically appropriate	0% Coinsurance.	0% Coinsurance.
See 5(c) for non-emergency service		

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

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment for Preferred Providers and \$4,000 for Self only enrollment and \$8,000 for Self and Family enrollment for Non-Preferred Providers each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...	
	Preferred Provider	Non-Preferred Provider
Mental health and substance abuse benefits	Preferred Provider	Non-Preferred Provider
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. 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.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<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 	\$0 Copayment.	50% Coinsurance.
<ul style="list-style-type: none"> • Diagnostic tests 	0% Coinsurance.	50% Coinsurance.
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	0% Coinsurance.	50% Coinsurance.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved</i> 	<i>All charges.</i>	<i>All charges.</i>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Mental health and substance abuse benefits (cont.)	Preferred Provider	Non-Preferred Provider
<p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
<p>Preauthorization</p>	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following Preauthorization processes:</p> <p>For Non-Preferred Providers: You must contact your Primary Care Physician for a referral before seeing any other Non-Preferred Provider or obtaining specialty services.</p> <p>A list of the Preferred Provider 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.</p>	
<p>Limitation</p>	<p>We may limit your benefits if you do not obtain a treatment plan.</p>	

Section 5(f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment for Preferred Providers and \$4,000 for Self Only enrollment and \$8,000 for Self and Family enrollment for Non-preferred Providers each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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. For members who take maintenance medication, you have three choices. Mail order prescriptions and **Choice 90Rx are optional and available only to members who take maintenance medication.**

Choice 1: Get a 30-day supply of medications for one copayment at a local retail pharmacy. This is the same benefit available for one-time prescriptions.

Choice 2: Get 90 days of maintenance medication through mail order and receive a discount.

Choice 3: Get 90 days of maintenance medication a local retail pharmacy and also receive a discount. You must take a prescription for a 90-day supply to a participating Choice90Rx pharmacy or have your prescription transferred to a Choice 90Rx pharmacy.

- **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 referring physician and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. Maintenance medication can be dispensed for up to a 90-day supply through mail order or at a pharmacy participating in Choice 90Rx.
- **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.
- **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.

Benefit Description	You pay After the calendar year deductible	
	Preferred Provider	Non-Preferred Provider
<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 referring physician and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply or manufacturer’s standard package. <p>For members who take maintenance medication and choose the options of mail order or Choice 90Rx at a participating pharmacy for a 90-day supply.</p> <ul style="list-style-type: none"> • 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>Tier 1 Drugs 0% Coinsurance.</p> <p>Tier 2 Drugs 0% Coinsurance.</p> <p>Tier 3 Drugs 0% Coinsurance.</p>	<p>Tier 1 Drugs 50% Coinsurance.</p> <p>Tier 2 Drugs 50% Coinsurance.</p> <p>Tier 3 Drugs 50% Coinsurance.</p> <p>(Plan Year Out-of-Pocket Maximum does not apply for Prescription Drugs purchased from a Non-Preferred Provider.)</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible	
Covered medications and supplies (cont.)	Preferred Provider	Non-Preferred Provider
<ul style="list-style-type: none"> • <i>First Month Free</i> – First Month Free allows for a free 30-day trial of any Tier 1 maintenance medication. Antibiotics, pain medications or short-term/periodic medication are not included. 	Nothing.	Nothing.
<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> 	<i>All charges.</i>	<i>All charges.</i>

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- The deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment for Preferred Providers and \$4,000 for Self Only enrollment and \$8,000 for Self and Family enrollment for Non-Preferred Providers each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
	Preferred Provider	Non-Preferred Provider
Accidental injury benefit		
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	0% Coinsurance.	50% Coinsurance.
Dental Benefits	Preferred Provider	Non-Preferred Provider
We have no other dental benefits		

Section 5(h). 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 less costly alternative benefits • 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	<p>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.</p>

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

Special features	Description
Health Education Resources	Visit www.bpcinc.com for educational material on HSA's, HRA's and HDHP's.
Consumer choice information	<p>As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.healthalliance.org.</p> <p>Link to online pharmacy through www.healthalliance.org.</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.bpcinc.com.</p>
Account management tools	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through www.bpcinc.com.</p> <p>Your balance will also be shown on your explanation of benefits (EOB) form.</p> <p>You will receive an EOB after every claim.</p> <p>If you have an HSA,</p> <ul style="list-style-type: none"> • You will receive a detailed statement of your account balance and activity for the month. • You may also access your account on-line at www.bpcinc.com. <p>If you have an HRA,</p> <ul style="list-style-type: none"> • Your HRA balance will be available online through www.bpcinc.com. <p>Your balance will also be shown on your EOB form.</p>
Care support	Patient safety information is available online at www.healthalliance.org .

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, please contact the Plan at 1-800-851-3379 or visit their website at www.healthalliance.org.

Medicare prepaid plan enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 91, 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.

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

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

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*)
- Services, drugs or supplies you receive while you are not enrolled in this Plan
- Services, drugs or supplies not medically necessary
- Services, drugs or supplies not required according to accepted standards of medical, dental or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or devices
- 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 services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

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

When you must file a claim – such as for services you received outside the Plan’s service area as a member of our High or Standard Options – 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, Inc.

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 benefits for your claim if you do not respond.

Section 8. The disputed claims process

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

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; andb) Send your request to us at: Health Alliance Medical Plans, 301 South Vine Street, Urbana, IL 61801; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) 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); orb) Write to you and maintain our denial - go to step 4; orc) 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: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">• 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. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

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.

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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 has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary 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 or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

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

• Should I enroll in Medicare?

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

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

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

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

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

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

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

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

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

When we are the primary 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. 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 – If you are enrolled in the High or Standard Option plan, 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: You may enroll in one of our Medicare Advantage plans and also remain enrolled in our FEHB plan. In this case, we do waive some cost sharing for your FEHB coverage.

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

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

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

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial Care	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 13.
Experimental or investigational service	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 essentially 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	A service or supply that is required to identify or treat a condition and is: <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.• Adequate and essential for the evaluation or treatment of a disease, condition or illness.• Can reasonably be expected to improve the member's condition or level of functioning.• Conforms with standards of good medical practice, uniformly recognized and professionally endorsed by the general medical community at the time it is provided.• Not mainly for the convenience of the member, a physician or other provider.• The most appropriate medical service, supply or level of care that can safely be provided. When applied to inpatient care, it further means that your medical symptoms or condition require that the services cannot be safely provided to you 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.

High Deductible Health Plan (HDHP) Definitions

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.
Catastrophic limit	Total out-of-pocket expenses including deductibles, copayments and coinsurance.
Health Reimbursement Arrangement (HRA)	An HRA is an employer funded account that can be used to pay for qualified medical expenses for you and any individuals covered by your High Deductible Health Plan.
Health Savings Account (HSA)	An HSA allows you to accumulate tax-free assets to pay current and future healthcare expenses. To open an HSA, you must have a qualifying high deductible health plan (HDHP) either through your employer or as an individual.
Premium Contribution to HSA/HRA	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS.

Section 11 FEHB Facts

Coverage Information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- 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 benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorcé, or when your child under age 22 marries.

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

Children's Equity Act

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2008 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 2007 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

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

Upon divorce

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

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Section 12. Three Federal Programs complement FEHB benefits

Important information

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

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

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

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). 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.

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. **Annuitants are not eligible to enroll.**

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

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

Where can I get more information about FSAFEDS?

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

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

- Important Information** The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employees Dental and Vision Benefits Enhancement Act of 2004. This Program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.
- Dental Insurance** Dental plans provide a comprehensive range of services, including the following:
- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
 - Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions and denture adjustments.
 - Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
 - Class D (Orthodontic) services with up to a 24-month waiting period.
- Vision Insurance** Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on lasik surgery may also be available.
- How do I enroll?** You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888- 3337 (TTY number, 1-877-889-5680).

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

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Cholesterol tests.....	19, 56	Laboratory and pathological services ...18, 59		Psychologist.....	39, 77
Claims.....	87	Machine diagnostic tests	18, 59	Psychotherapy.....	39, 77
Coinsurance.....	13	Magnetic Resonance Imaging (MRIs)...18, 59		Radiation therapy	22, 61
Colorectal cancer screening.....	19, 56	Mail Order Prescription Drugs.....	42, 80	Renal dialysis.....	23, 61
Congenital anomalies.....	29, 67	Mammograms.....	19, 56	Room and board.....	34, 72
Contraceptive devices and drugs.....	20, 60	Maternity Benefits.....	20, 60	Second surgical opinion	18, 59
Coordination of benefits.....	90	Medicaid.....	94	Skilled nursing facility care.....	35, 73
Covered charges.....	13	Medically necessary.....	95	Smoking cessation.....	26, 65
Covered providers.....	10	Medicare.....	90	Speech therapy.....	23, 64
Crutches.....	23, 64	Mental Conditions/Substance Abuse Benefits.....	39, 77	Splints.....	35, 72
Deductible	13	Neurological testing	18, 59	Subrogation.....	90
Definitions.....	95	Newborn care.....	20, 60	Substance abuse.....	39, 77
Dental care.....	44, 82	Non-FEHB benefits.....	85	Surgery.....	28, 66
Diagnostic services.....	18, 59	Nursery charges.....	20, 60	Syringes.....	42, 80
Disputed claims review.....	88	Obstetrical care	20, 60	Temporary continuation of coverage ...99	
Donor expenses (transplants).....	32, 70	Occupational therapy.....	85	Transplants.....	30, 68
Dressings.....	33, 72	Ocular injury.....	24, 63	Treatment therapies.....	22, 61
Durable medical equipment (DME)...25, 64		Office visits.....	18, 59	Vision services	24, 63
Educational classes and programs ...26, 65		Oral and maxillofacial surgery.....	30, 68	Well-child care	19, 57
Effective date of enrollment.....	98	Orthopedic devices.....	25, 64	Wheelchairs.....	25, 64
Emergency.....	36, 75	Ostomy and catheter supplies.....	25, 64	Workers' compensation.....	94
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Summary of benefits for the High Option of the Health Alliance HMO Plan - 2008

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

Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copayment: \$15 primary care; \$25 specialist	18
Services provided by a hospital:		
• Inpatient	\$500 copayment per admission	34
• Outpatient	\$100 per outpatient surgical admission	35
Emergency benefits:		
• In-area	\$15 physician office/\$100 hospital ER	37
• Out-of-area	\$15 physician office/\$100 hospital ER	37
Mental health and substance abuse treatment:	Regular cost sharing	39
Prescription drugs:		
• Retail pharmacy	\$10/\$20/\$40	41
• Mail order	\$27.50/\$55/\$110	41
Dental care:	No benefit.	44
Vision care:	\$15 copayment per exam at a Primary Care Physician. \$25 copayment per exam at a Specialist.	24
Special features:		45
• Flexible benefits option		
• Services for deaf and hearing impaired		
• Reciprocity benefits		
Protection against catastrophic costs (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 Pharmacy Drugs is \$1,500 per member or \$3,000 per family	13

Summary of benefits for the Standard Option of the Health Alliance HMO - 2008

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

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$20 primary care; \$35 specialist	18
Services provided by a hospital:		
• Inpatient	20% coinsurance per admission	34
• Outpatient	20% coinsurance per visit	35
Emergency benefits:		
• In-area	\$20 physician office/\$150 hospital ER	38
• Out-of-area	\$20 physician office/\$150 hospital ER	38
Mental health and substance abuse treatment:	Regular cost sharing	39
Prescription drugs:		
• Retail pharmacy	\$20/\$35/\$50	41
• Mail order	\$55/\$96.25/\$137.50	41
Dental care:	No benefit	44
Vision Care:	\$20 copayment per exam at a Primary Care Physician. \$35 copayment per exam at a Specialist.	24
Special Features:	<ul style="list-style-type: none"> • Flexible benefits option • Services for the deaf and hearing impaired • Reciprocity benefits 	45
Protection against catastrophic costs (out-of-pocket maximum):	<p>Nothing after \$2,500/Self Only or \$5,000/Family enrollment per year</p> <p>Some costs do not count towards this protection</p> <p>The out-of-pocket maximum for Specialty Pharmacy Drugs is \$1,500 per member or \$3,000 per family</p>	13

Summary of benefits for the HDHP of Health Alliance Medical Plans - 2008

Do not rely on this chart alone. All benefits are subject to the definitions, limitations and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2008 for each month you are eligible for the HSA, will deposit \$83.33 per month for Self Only enrollment or \$166.67 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you must satisfy your calendar year deductible of \$2,000 for Self Only and \$4,000 for Self and Family for Preferred Providers or \$4,000 for Self Only and \$8,000 for Self and Family for Non-Preferred Providers before using your HSA. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$1,000 for Self Only and \$2,000 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

Below, an asterisk (*) means the item is subject to the calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You pay	Page
Medical preventive care at a Preferred Provider and Non-Preferred Provider:	\$25 copayment for Preferred Providers for routine exams, \$0 copayment for other preventative care at a Preferred Provider. 50% coinsurance for all preventative care at Non-Preferred Providers.	56
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$0 copayment for Preferred Providers*/50% coinsurance for Non-Preferred Providers*	59
Services provided by a hospital:		
• Inpatient	0% coinsurance for Preferred Providers*/50% coinsurance for Non-Preferred Providers*	72
• Outpatient	0% coinsurance for Preferred Providers*/50% coinsurance for Non-Preferred Providers*	73
Emergency benefits:		
• In-area	0% coinsurance for Preferred Providers* and Non-Preferred Providers*	76
• Out-of-area	0% coinsurance for Preferred* and Non-Preferred Providers*	76
Mental health and substance abuse treatment:	Regular cost sharing*	77
Prescription drugs:		
• Retail Pharmacy	0% coinsurance for Preferred Providers*/50% coinsurance for Non-Preferred Providers*	79
• Mail order	0% coinsurance for Preferred Providers*/50% coinsurance for Non-Preferred Providers*	79
Dental care:	No benefit	82
Vision care:	\$0 copayment for Preferred Providers*/50% coinsurance for Non-Preferred Providers*	63

Benefits	You pay	Page
Special features: <ul style="list-style-type: none"> • Flexible benefits option • Services for deaf and hearing impaired • Reciprocity benefits 		83
Protection against catastrophic costs (out-of-pocket maximum):	The yearly out-of-pocket maximum is \$2,000 for self and \$4,000 for family for Preferred Providers or \$10,000 for self and \$20,000 for family for Non-Preferred Providers	13

2008 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 *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

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

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

For further assistance, Postal Service employees should call.

Human Resources Shared Service Center

1-877-477-3273, Option 5

TTY: 1-866-260-7507

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	FX1	145.05	81.49	314.25	176.57	57.31	55.30
High Option Self and Family	FX2	329.30	199.42	713.48	432.08	144.54	139.96
Standard Option Self Only	FX4	125.54	41.85	272.01	90.67	20.92	18.83
Standard Option Self and Family	FX5	317.53	105.84	687.98	229.32	52.92	47.63
HDHP Option Self Only	FM1	135.80	45.16	293.57	97.86	22.58	20.32
HDHP Option Self and Family	FM2	303.69	101.23	658.00	219.33	50.61	45.55