HealthPlus of Michigan

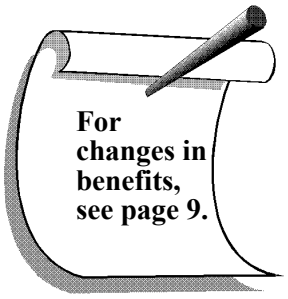
http://www.healthplus.org

2009

A Health Maintenance Organization

Serving: East Central Michigan

Enrollment in this Plan is limited. You must live in our Geographic service area to enroll. See page 8 for requirements.



This plan has excellent accreditation from the NCQA. See the 2008 guide for more information on accreditation.

Enrollment codes for this Plan:

X51 Self Only
X52 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 73-648

Important Notice from HealthPlus of Michigan About

Our Prescription Drug Coverage and Medicare

OPM has determined that the HealthPlus of Michigan plan'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 benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and HealthPlus of Michigan 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 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what 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 Benefit

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this plan 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 HealthPlus of Michigan under our contract (CS 2712) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for HealthPlus of Michigan administrative offices is:

HealthPlus of Michigan, Inc.
2050 South Linden Road
P.O. Box 1700
Flint, MI 48501-1700

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, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means HealthPlus of Michigan.
- 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 fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits 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 doctor, other provider, or authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statement that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

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

If the provider does not resolve the matter, call us at 800-332-9161 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, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise);
  - 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.

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.

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.

Who provides my healthcare?

Each family member that is covered by HealthPlus must choose a Primary Care Physician from the Provider Directory (parents are expected to select for their children). This list includes hundreds of doctors who specialize in Family Practice, Internal Medicine, or Pediatrics. The listing for each Primary Care Physician also shows a "primary hospital." This is the hospital where your Primary Care Physician will direct you for hospital services in most instances. When you select a Primary Care Physician, you also are agreeing to use the hospital listed.

The Primary Care Physician you choose will coordinate your overall medical care, including arranging for hospital admissions or care by a specialist when medically necessary with the following exception: a woman may see her Plan gynecologist for her annual routine examination or routine obstetrical services without a referral.

HealthPlus strives to keep the Provider Directory as up-to-date as possible. However, information may change after the Directory has been printed. If the physician you select is no longer accepting patients, please select another. You may want to call the physician you have chosen prior to calling the HealthPlus Customer Service Department at (800) 332-9161 with your selection. You must notify HealthPlus before receiving covered services from the new Primary Care Physician.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, our providers, and our 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.

- HealthPlus service area
- HealthPlus Federal brochure
  - Covered benefits, including prescription drug coverage
  - Description of emergency health coverages and benefits
  - Out-of-area coverage and benefits
  - An explanation for copayments and any other out-of-pocket expense
- Continuity of treatment
  - Arrange for the continuation of treatment by that provider; or
  - Assist the member in selecting a new provider
- Additional information

- Provider information
- Physician credentials
- Physician status/discipline
- Specific benefits
- Financial arrangement with physicians
- Who to contact

- Years in existence
- Profit status

If you want more information about us, call 800-332-9161, or write to our Customer Service Department at: 2050 South Linden Road, P.O. Box 1700, Flint, MI 48501-1700. You may also contact us by fax at 810-230-2093 or visit our Web site at www.healthplus.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 our Service Area. This is where our providers practice.

Our service area includes Arenac, Bay, Clare, Genesee, Gladwin, Gratiot, Isabella, Lapeer, Livingston, Macomb, Midland, Montcalm, Oakland, Saginaw, Sanilac,Shiawassee, and Tuscola Counties in Michigan,with exceptions as outlined below.

Townships noted in the following counties are not listed in the HealthPlus coverage area: GLADWIN COUNTY: Bourret Township. GRATIOT COUNTY: Elba Township, Ashley Village, Fulton Township, North Shade Township and Perrinton Village. ISABELLA COUNTY: Broomfield Township, Deerfield Township, Fremont Township, Rolland Township and Sherman Township. MIDLAND COUNTY: Geneva Township. SANILAC TOWNSHIP: Bridgehampton Township, Buel Township, Croswell Township, Custer Township, Elk Township, Forester Township, Fremont Township, Greenleaf Township, Lexington Township, Marion Township, Sanilac Township, Speaker Township, Washington Township, Wheatland Township, Worth Township.

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 you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. Eligible college students are covered for emergency illnesses or injuries that occur when they are out of the service area. 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 2009

The office visit copay will change from $10 for all office visits to: $10 for PCP office visits, and $20 for specialist office visits, including mental health and substance abuse outpatient services.

Emergency services copays will change from the current $25 for all emergency services to $25 for services provided at a freestanding urgent care center and $75 for services at a hospital emergency room. Hospital emergency room copay is waived if you are admitted to the hospital.

Our service area now includes Macomb County in Michigan.

Your share of the postal or non-postal premium will increase for 2009. See back cover.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-332-9161 or write to us at P. O. Box 1700, Flint, MI 48501-1700. You may also request replacement cards through our Web site at www.healthplus.org.

Where you get covered care

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

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. Participating providers strive to provide quality health care consistent with recognized medical standards, HealthPlus policy, and your subscriber benefits. Health care services must be obtained through, or under the direction of, your Primary Care Physician. He or she will coordinate your health care and, when medically necessary, refer you to a specialist from our network of health care providers. Your role is to always work with your Primary Care Physician for your health care needs. The selection of your Primary Care Physician is the key to obtaining the benefits available to you.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site. The HealthPlus Provider Directory is a convenient reference that lists independent primary physicians, specialist physicians, and other health care providers who have agreed to provide services to HealthPlus members. This directory will assist you in the selection of a Primary Care Physician for you and each member of your family.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Each family member that is covered by us must choose a Primary Physician from the Provider Directory (parents are expected to select for their children). This list includes doctors who specialize in Family Practice, Internal Medicine, or Pediatrics. The listing for each Primary Care Physician also shows a "primary hospital." This is the hospital where your Primary Care Physician will direct you for hospital services in most instances. When you select a Primary Care Physician you are also agreeing to use the hospital listed. The Primary Care Physician you choose will coordinate your overall medical care, including arranging for hospital admissions or care by a specialist when medically necessary. HealthPlus strives to keep the Provider Directory as up-to-date as possible. However, information may change after the Directory has been printed. If the Physician you select is no longer accepting patients, please select another. You may call our Customer Service Department at (800) 332-9161 with your selection. You must notify us before receiving covered services from the new Primary Care Physician.

- **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 see a participating mental health or substance abuse provider for an initial office visit without a referral, but continued coverage is dependent upon approval of the provider's treatment plan. Females may see a participating obstetrician or gynecologist for a well-woman exam once per year without a referral.

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

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

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

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

- **Hospital care**

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

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

We pay for covered services from the effective date of enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-332-9161. 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.

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.

Your Primary Care Physician or specialist, to whom you have been appropriately referred, is responsible for coordinating any necessary hospitalizations. Scheduled admissions require advance authorization from HealthPlus. Emergency admissions require notification of HealthPlus within 24 hours, or as soon thereafter as possible. Authorization occurs when we approve the admission and issue a complete authorization number to the hospital. The telephone number to call is on the back of your identification card.

Section 4. Your costs for covered services

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

Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay $100 per admission.
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.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. We do not have a deductible. 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 allowance that you must pay for your care. We do not have coinsurance.
Your catastrophic protection out-of-pocket maximum	We do not have a catastrophic protection out-of-pocket maximum. Your out-of-pocket expenses covered under this Plan are limited to stated copayments that are required for a few benefits.
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 coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.
When Government facilities bill us	Facilities of the Department Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

Section 5. High Option Benefits

(See page 9 for how our benefits changed this year and page 73 for a benefits summary.)

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Section 5. Benefits Overview

The High Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms,claims filing advice, or more information about our benefits, contactus at 800-332-9161 or at our Web site at www.healthplus.org.

- **High Option**

The HealthPlus HMO for Federal employees provides you with the following Benefit/cost advantages:

- No deductibles
- $10 office visit copay with your PCP, $20 for specialist visits
- $10 generic/$20 brand prescription copay
- Prescription copay savings when you "Ask for 90"
- No copay for hospital services

Here are some other great features:

- ***Customer service you can count on.*** Almost three decades of serving mid-Michigan with more than 200,000 members. It adds up to the experience and commitment to provide you with the highest quality care. When you call our Customer Service Department, you'll speak with a real person who is dedicated to providing you with a quick response to your questions and concerns.
- ***Save on prescriptions with "Ask for 90 Rx".*** Pay up to one third less on your prescriptions copays when you pay once to fill a 90-day prescription at a participating pharmacy vs. filling the same prescription three times in three months.
- ***A growing service area and provider network!*** To better serve our members, we've recently expanded our service area into Macomb and Oakland counties. Plus, you have access to a growing network of physicians, specialists, pharmacies and hospitals throughout mid-Michigan.
- ***Keeping members healthy with HealthQuest Health & Wellness Online*** - An invaluable source of interactive information on how to eat right, stay fit and stay healthy. Complete the "HealthQuest Profile" health risk assessment and develop your own personal wellness page based on your health risks and interests or record and manage your own "Personal Health Record" so your health history is easy to access when you need it. Plus, we have tools to help you set up health-smart goals like smoking cessation or weight loss and keep track of your progress.
- ***HealthQuest Rewards Program*** - Enjoy discounts on services, products and medical supplies from BarnesandNoble.com, Diet Workshop, EdgePark Medical Supply, EyeMed Vision Care, GlobalFit, Jenny Craig and Weight Watchers. Plus, as an added incentitve through our Weight Watchers partnership, HealthPlus will reward you for participating in the Weight Watchers offering of your choice! Simply complete 10 weeks of your Weight Watchers plan and HealthPlus will reimburse you half of your cost (a maximum reimbursement of $83).

For more information about HealthPlus benefits for Federal Employees visit www.healthplus.org/federal.aspx

Customer Service: 1-800-332-9161
T.D.D. 1-800-992-5070

Web: www.healthplus.org

Walk-In Customer Service available weekdays, 8 a.m. - 5 p.m. at:
FLINT 2050 S. Linden Rd., Flint, MI 48532
SAGINAW 5454 Hampton Place, Saginaw, MI 48604

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

Here are some 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.
- We have no calendar year deductible
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office	$10 per office visit with your PCP $20 per office visit with a specialist
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment by the member's primary care physician • Office medical consultations • Second surgical opinion	$25 per visit Nothing Nothing Nothing if examination occurs during hospital stay; otherwise, $10 per visit $10 per office visit with your PCP $20 per office visit with a specialist $10 per office visit with your PCP $20 per office visit with a specialist
At home	$10 per visit with your PCP $20 per visit with a specialist
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Benefit Description	You pay
Preventive care, adult	**High Option**
Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50	$10 per office visit with your PCP $20 per office visit with a specialist
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	$10 per office visit with your PCP $20 per office visit with a specialist
Routine Pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	$10 per office visit with your PCP $20 per office visit with a specialist
Routine mammogram – covered for women age 35 and older, as follows: • Baseline by the age of 40 • From age 40 through 49, one mammogram every one or two years • At age 50, one yearly	$10 per office visit with your PCP $20 per office visit with a specialist
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC).	Nothing
Not covered: • Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel. • Examinations, reports or any other services related to requirements or documentation or health status for employment, licenses, insurance, travel, or for educational or sports/recreational purposes.	*All charges*
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction	$10 per office visit with your PCP $20 per office visit with a specialist

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
- Examinations done on the day of immunizations (up to age 22)	$10 per office visit with your PCP $20 per office visit with a specialist
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below 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. (Note: Surgical benefits, not maternity benefits, apply to circumcision) • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 for initial visit, nothing thereafter
Not covered: Routine sonograms to determine fetal age, size or sex.	*All charges*
Family planning	**High Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Medically-indicated genetic testing and counseling per generally accepted medical practice Note: We cover oral contraceptives under the prescription drug benefit.	Nothing

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	**High Option**
Not covered: • Reversal of voluntary sterilization and all associated cost • Premarital exams or classes.	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) • Fertility drugs Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	$10 per office visit with your PCP $20 per office visit with a specialist
Not covered: • Assisted reproductive technology (ART) procedures, such as: • in vitro fertilization • embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) • Services and supplies related to ART procedures • Reversal of a voluntary sterilization and all associated costs • Pre-embryo cryo preservation techniques and associated services • Infertility services if one of the partners has previously undergone surgical sterilization or if one of the partners is menopausal or post menopausal • All services related to a surrogate parenting arrangements of any kind • *Cost of donor sperm and all associated costs* • *Cost of donor egg*	*All charges*

Benefit Description	You pay
Allergy care	**High Option**
• Testing and treatment • Allergy injections	$10 per office visit with your PCP $20 per office visit with a specialist
Allergy Serum	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 28. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: – We only cover GHT when we preauthorize the treatment. Your Primary Care Physician calls us for a referral. We will ask you to submit information that establishes that the GHT is medically necessary. The submitted request is reviewed by our Medical Director to determine medical necessity. 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.	$10 per office visit with your PCP $20 per office visit with a specialist
Physical and occupational therapies	**High Option**
Two consecutive months per condition are covered if significant improvement can be expected within the two months. Services are covered for each of the following: • qualified physical therapists and • occupational therapists 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.	Nothing

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	**High Option**
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is covered with no visit limits.	Nothing
Not covered: • Long-term rehabilitative therapy • Exercise programs • Vocational rehabilitation services	*All charges*
Speech therapy	**High Option**
60 visits per condition	Nothing
Hearing services (testing, treatment, and supplies)	**High Option**
• Benefits for a Hearing aid and hearing tests for fitting and post performance evaluation of a Hearing aid.	Nothing
Not covered: • Hearing aids ordered prior to the effective date of coverage under this contract • Replacement and/or repair because of loss or misuse; • *Batteries* • *The additional cost of an eyeglass-type Hearing aid or other Hearing aid with special features that are not medically necessary over the conventional type of Hearing aid.*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
Initial pair of glasses after cataract surgery	$10 per office visit with your PCP $20 per office visit with a specialist
Eye exam to determine the need for vision correction for children through age 17. (See Preventive Care, Children)	$10 per office visit with your PCP $20 per office visit with a specialist
Not covered: • Refractions • Eyeglasses or contact lenses and examinations for them • Eye exercises and orthoptics • *Radial keratotomy and other refractive surgery* • *Eyeglasses for ocular injury*	*All charges*

Benefit Description	You pay
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit with your PCP $20 per office visit with a specialist
Not covered: • *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)*	*All charges*
Orthopedic and prosthetic devices	**High Option**
Orthotic appliances and prosthetic devices (including breast prosthesis following a mastectomy) • 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. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Nothing
Not covered: • Equipment that is not deemed medically necessary or is an upgrade to accepted standards. • *Orthotic appliances when they are not used to support, align, prevent, correct or improve a defect of body form or function.*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**High Option**
• *Prosthetic devices when they do not replace a limb or other part of the body after accidental or surgical removal and/or when your body growth necessitates a replacement.*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps.	Nothing
Not covered: Equipment that is not deemed medically necessary or is an upgrade to accepted standards..	*All charges*
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • 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. • Personal comfort or convenience items such as television and telephone services • *Skilled nursing services provided on a twenty-four (24) hour basis in the home* • *Private duty nursing services (except if medically necessary in an inpatient setting).*	*All charges*

Benefit Description	You pay
Chiropractic	**High Option**
• Spinal Manipulation when provided by, or under the direction of, your Primary Care Physician, or provided by a Specialist Physician to whom you are appropriately referred.	$10 per office visit with your PCP $20 per office visit with a specialist
Not covered: • Hypnosis • *Biofeedback* • *Acupuncture*	*All charges*
Alternative treatments	**High Option**
No benefit	*All charges*
Educational classes and programs	**High Option**
HealthPlus HealthQuest offers many educational programs to keep our members healthy and to engage members to improve their health if they wish to participate. In summary, HealthPlus HealthQuest offers the following programs: **HealthQuest Tobacco Cessation Program**: Designed to help you find a way that is best for you to quit smoking and stay smoke free. HealthPlus offers members a variety of resources and services free-of-charge when you are ready to quit. the program has many options to choose from, including: • **Quit Kit**: A free self-directed kit that deals with the behaviors associated with quitting. Support materials included guide you through the quitting process. • **Community Classes**: A listing of classes taught in the community. HealthPlus will reimburse at the completion of the course with an original receipt and certificate of completion. • **Phone Counseling**: Free phone counseling in which trained health coaches will work with you over the phone to identify a personalized cessation method that focuses on behavioral and lifestyles issues. Members may also elect to do program online with the phone coach or to do online exclusively. Once you sign up for phone counseling , you will also receive a quit kit in the mail and have the option to receive e-mails and/or participate in a web-based support program. If you think telephone counseling is right for you, enroll by calling 1-800-345-9956, ext 1943 or by visiting www.quitnet.com/healthplus. • **Prescription Benefits**	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
HealthQuest Weight Management Program: Designed to help you manage your weight and improve your lifestyle. HealthPlus offers members a variety of resources and services free-of-charge. The program has many options to choose from, including: • **iCanChange Online Coaching**:Available to HealthPlus HMO members who are looking for help losing weight. Members will be assigned a personal health coach that will assist them in their weight management efforts online. To get registered: Members can call 1-800-345-9956, extension 1943, option 3 or email hquest@healthplus.org (including your name and member number). • **iCanChange Phone Coaching**:Available to HealthPlus HMO members whose weight puts them at risk for developing disease and may already have chronic health conditions such as high blood pressure and/or diabetes. This 12 month program is designed to give members the advantage of the iCanChange online coaching as well as phone coaching and an iCanChange kit that includes a workbook, pedometer and measuring tape. Members will be assigned to a personal health coach that will motivate and help them with weightmanagement for one year! Members must meet risk requirements to qualify for this program. To get registered: call 1-800-345-9956, extension 1943, option 3. Or email hquest@healthplus.org (including your name and member number) • **HealthQuest Rewards**: All HealthPlus members can take advantage of HealthQuest Rewards. Some of the Rewards include: - **Diet Workshop**:Learn "The 7 Keys to Healthy Weight Management" - Attitude Awareness, Commitment, Planning, Food Choices, Food Portions and Exercise. TheDiet Workshop offers classes in a variety of locations. Registration is $10 and $8 per week thereafter. - **Jenny Craig**:HealthPlus and Jenny Craig have teamed up to assist you by offering a free 30 day introductory program and discounts on both their 6 month and 12 month programs.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
- **Weight Watchers**:HealthPlus members are eligible to receive special savings. Great rates are available on three proven weight management plans: Weight Watchers Local Meetings, Weight Watchers Online and Weight Watchers At Home. And, as an added incentive, HealthPlus will reward its members for participating in the weight management offering of their choice! Simply complete 10 weeks of your Weight Watchers plan and HealthPlus will reimburse half of your cost (a maximum reimbursement of $83)! - **GlobalFit**:GlobalFit is a benefit that is offered to all HealthPlus members. GlobalFit makes it easy and affordable to join a fitness club by providing up to 60% off regular club rates and month-to-month memberships at over 10,000 quality fitness clubs nationwide. - **HealthQuest Health & Wellness Online**:With HealthPlus, you can take advantage of our year-round program that offers a variety of wellness activities to help you feel great, boost energy and learn more about your health. Whether you are in good health or need a plan to get started, these wellness activities will help improve your quality of life. HealthQuest Health & Wellness Online benefits and features include: - **Your Health**- Assess your own health by completing the HealthQuest Profile, develop your own personal wellness page based on your health risks and interests, then design your personalized health management plan. - **Healthy Living Programs**- After assessing your health, you will be encouraged to participate in any of the 13 online healthy living programs. These six-week programs will help you reach your health goals at your own pace. - **Health Challenges** - HealthQuest challenges you to improve your health by offering up to four online challenges a year! - **Personal Health Record**- Record and manage your health history and your family members' health history in a personal health record that's completely confidential, secure and easy to access and share with your physician. - **Daily Health News** - Features the most relevant and current health headlines.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
- **Medical Resources** - Men, women, children and older adults can find information regarding common health issues to improve their health. - **Health Encyclopedia** - Simple, free access to information on over 3,000 health topics on disease, drug information, health news, recipes and more! - **Habitracker** - Record your daily activities, nutrition choices and body data. - **Interactive Tools** - Check out the virtual trainer, sandwich maker, calculators and health quizzes designed to help you improve your health. **HealthQuest Health Information Phone Line**:You can call HealthPlus to request any type of health information. The line is set up with nine different options of specific topics, such as lead testing, tobacco cessation and more. Simply call our toll free number, 1-800-345-9956, extension 1943 and select the information topic you need assistance with and we will follow-up with you to get you the information you need. **HealthQuest Online Healthy Living Programs**: Plan members have access at no cost to any of our online twelve six-week, six-session online Healthy Living Programs. All programs are completely self contained and are designed to help members understand more about their risk factors and make lifestyle changes at their own pace. The programs included are: • **Healthier Diet** - This program shows you simple solutions to improve your diet. • **Get In Shape** - This program makes it easy to start an exercise program and get into shape. • **Stress Relief** - This program gives you the tools to help reduce and manage stress. • **Diabetes Fighting** - This program helps you make small changes today that will have long-term results to prevent diabetes. • **Healthy Heart** - This program helps you make small changes today that will have long-term results to prevent heart disease. • **Weight Loss** - This program is a no hype alternative that helps you lose weight the right way. • **Smoke-Free** - This program gives you the resources to help you meet the challenges of quitting for life.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
• **Healthy Aging** - This program can help you look good, feel younger and reduce your risk of disease. • **Cancer-Fighting** - This program helps you eat healthier and increase your activity - two of the best weapons against disease. • **Easy Start** - This program gives you simple guidelines to help you change your diet and get more active. • **Custom Program** - This program will give you access to all the site's interactive tools and resources to help you reach your health goals. • **Healthy Seniors** - If you are over the age of 65, this program can help you take steps to improve your health. • **Healthier Diet** - This program shows you simple solutions to improve your diet. • **Get In Shape** - This program makes it easy to start an exercise program and get into shape. • **Stress Relief** - This program gives you the tools to help reduce and manage stress. • **Diabetes Fighting** - This program helps you make small changes today that will have long-term results to prevent diabetes. • **Healthy Heart** - This program helps you make small changes today that will have long-term results to prevent heart disease. • **Weight Loss** - This program is a no hype alternative that helps you lose weight the right way. • **Smoke-Free** - This program gives you the resources to help you meet the challenges of quitting for life. • **Healthy Aging** - This program can help you look good, feel younger and reduce your risk of disease. • **Cancer-Fighting** - This program helps you eat healthier and increase your activity - two of the best weapons against disease. • **Easy Start** - This program gives you simple guidelines to help you change your diet and get more active. • **Custom Program** - This program will give you access to all the site's interactive tools and resources to help you reach your health goals. • **Healthy Seniors** - If you are over the age of 65, this program can help you take steps to improve your health.	Nothing
Not covered: Premarital exams or classes	*All charges*

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

Here are some 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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR 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.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery • Surgical treatment of morbid obesity (bariatric surgery) - a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over - the Plan Medical Director may authorize bariatric surgery (Roux-en Y, vertical banded gastroplasty or laproscopic surgery) for members over age 18, when certain criteria are met and documented by the member's PCP	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
- generally, HealthPlus requires the member to be 100 pounds or more overweight (depending on height); have at least one additional risk factor, such as heart disease, or diabetes; undergo an evaluation to rule out other causes of obesity; document compliance with a medically prescribed diet and weight loss regimen for a minimum of six (6) months; and, undergo counseling to ensure understanding of the procedure and its risks and limitations • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns 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.	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - 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: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas;	Nothing

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
- breast prostheses and surgical bras and replacements (see *Prosthetic devices*) 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.	Nothing
Not covered: • 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 • Surgeries related to sex transformation • *Other services and procedures for Cosmetic purposes, such as procedures to correct baldness or wrinkling* • *Wigs, prosthetic hair, hair transplants, or other procedures or supplies to enhance hair growth*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Orthognathic surgery prior to the age of twenty-one (21) for congenital defects directly affecting the growth, development, and function of the jaw; • Hospitalization charges for multiple extractions which must be performed in a Hospital due to a concurrent hazardous medical condition; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • Oral implants and transplants • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) • *Dental care and associated supplies, services, and tests, except as specifically provided in this section.*	*All charges*

Benefit Description	You pay
Organ/tissue transplants	**High Option**
Solid organ transplants are subject to medical necessity and experimental investigational review. Refer to *Other Services* in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description. • Cornea • Heart • Heart/lung • Kidney • Liver • Single, double or lobar lung • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	Nothing
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Hemoglobinopathy (i.e. Fanconi's Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis • Autologous transplants for	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - De-novo myeloma	Nothing
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Allogeneic transplants for - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Pineoblastoma	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Waldenstrom's macroglobulinemia Mini-transplants (non-myeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity Tandem transplants for covered transplants: Subject to medical necessity	
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. • Allogeneic transplants for - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes - Multiple myeloma - Multiple sclerosis • Nonmyeloablative allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Myelodysplasia/myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma - Multiple sclerosis	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas • Autologous transplants for - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) - - Note: We cover related medical and hospital expenses of the donor when we cover the recipient. - National Transplant Program (NTP): A case manager is assigned upon notification of a member needing a transplant. The physician, member and case manager develop a treatment plan specific to the member's medical needs.	Nothing
Not covered: • Donor screening tests and donor search expenses, except those performed for the actual donor • Medical expenses incurred by a non-Member who donates an organ or tissue to a Member will only be covered if the non-Member does not have coverage for these services. • Implants of artificial organs • Transplants not listed as covered	*All charges*

Benefit Description	You pay
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Freestanding emergency center • Office	Nothing

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

Here are some 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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by 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
Inpatient hospital	**High Option**
Room and board, such as • 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.	Nothing
• Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: • Custodial care or domiciliary care, basic care, or housekeeping	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• Non-covered facilities, such as nursing homes, schools • Services or products provided by convalescent homes, homes for the aged, or adult foster care facilities • Personal comfort items, such as telephone, television, barber services, guest meals and beds • *Private duty nursing, unless medically necessary* • *Blood and blood derivatives not replaced by the Member*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• 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 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.	Nothing
Not covered: • Custodial or domiciliary care, basic care, or housekeeping • Personal comfort or convenience items such as television and telephone services • *Blood and blood derivatives not replaced by the member* • *Private duty nursing*	*All charges*

Benefit Description	You pay
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Benefits for care in a skilled nursing facility shall be limited to a maximum of one hundred (100) days per Member per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan	Nothing
Not covered: • Custodial or domiciliary care, basic care, or housekeeping • Personal comfort or convenience items such as television and telephone services • *Private duty nursing services* • *Blood and blood derivatives not replaced by the member*	*All charges*
Hospice care	**High Option**
Hospice services provided by a Hospice under the direction of a Plan doctor who certifies that the member is in the terminal stages of illness, with a life expectancy of approximately six months or less. Services must be ordered by your Primary Care Physician and authorized in advance by us. Services are limited to: • Room and board charges • Medical supplies, drugs and medicines • Medical-social services	Nothing
Not covered: • Custodial or domiciliary care, basic care • Independent nursing, homemaker services • Personal comfort or convenience items such as television and telephone services • *Private duty nursing services* • *Skilled nursing services provided on a twenty-four (24) hour basis in the home*	*All charges*

Benefit Description	You pay
Ambulance	**High Option**
Local professional ambulance service when medically appropriate	Nothing

Section 5(d). Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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: Members are covered for treatment when a true emergency exists. If you are in doubt of the seriousness of the medical condition and have time to call your Primary Care Physician, you should do so. If your physician feels that the problem requires immediate attention, he or she will direct your treatment. Please note: Emergency health services rendered by a participating provider within our service area are covered. Also, services will be covered if they are rendered by a non-affiliated provider because an emergency prevents you from receiving services from a participating provider.

Emergencies outside our service area: In case of an emergency when you are out of the HealthPlus service area, we provide coverage for necessary care. If your problem is too serious to wait until you return to the HealthPlus service area, go to a physician, after-hours care center, or the hospital nearest you for treatment. Emergency admissions require notification to HealthPlus within 24 hours, or as soon thereafter as possible. You may call HealthPlus 24 hours a day at the Emergency Services number on the back of your HealthPlus identification card. Please call promptly after an emergency in order to confirm coverage, ensure proper follow-up care and assure payment for covered services you receive.

Note: We reserve the right not to pay for non-emergency treatment received at emergency facilities. If you are hospitalized at non-affiliated hospital, you may be transferred to an affiliated hospital upon request of your Primary Care Physician as soon as it is medically appropriate in the opinion of the attending physician. Should you, or your designee, refuse a transfer to an affiliated hospital, continued care provided to you at a non-affiliated hospital shall not constitute covered services and shall no longer be the financial responsibility of us. Follow-up visits to non-affiliated providers of emergency health services outside the service area shall be limited to two (2) Visits within thirty (30) days of the emergency, or the number of visits specified in a treatment plan approved by us.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at a doctors' office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services • NOTE: Emergency care, urgent care center and hospital copay waived if you are admitted to a hospital.	$10 per visit with your PCP $20 per visit with a specialist $25 per visit at an urgent care center $75 per visit at a hospital emergency room
Not covered: • *Elective care or non-emergency care* • *Blood and blood derivatives not replaced by the member*	*All charges*
Emergency outside our service area	**High Option**
• Emergency care at a doctors' office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services • NOTE: Emergency care, urgent care center and hospital emergency room copay waived if you are admitted to a hospital.	$10 per visit with your PCP $20 per visit with a specialist $25 per visit at an urgent care center $75 per visit at a hospital emergency room
Not covered: • *Elective care or non-emergency care* • *Blood and blood derivatives not replaced by the member*	*All charges*

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.

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

Benefit Description	You pay
Mental health and substance abuse benefits	**High Option**
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.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$20 per visit
Diagnostic tests • 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	Nothing Nothing
Not covered: Services we have not approved. *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.*	*All charges*

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

	We have designated mental health/substance abuse providers throughout our service area. The program's preferred provider panel is comprised of a select group of psychiatrists, psychologists, social workers and substance abuse providers. You may obtain mental health/substance abuse services from our preferred providers without a referral from your Primary Care Physician. Services from mental health/substance abuse providers not on our preferred provider panel require prior authorization from us. For coverage of mental health and substance abuse services, you may access your benefits in any of the following ways: 1. Call the HealthPlus Behavioral Service department at 800-555-5025. 2. Contact a panel provider from the HealthPlus Provider Directory and schedule an appointment. The provider you select will obtain the referral. 3. Contact your Primary Care Physician to coordinate your care. Because our preferred panel of providers changes periodically, you may want to obtain an updated list by calling our Behavioral Services department at 800-555-5025.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** Prescriptions for covered drugs must be written by your Primary Care Physician or by a specialist to whom you have been appropriately referred**.**
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy, or through Express Scripts. A list of participating pharmacies may be found in our Provider Directory. If you have questions about mail order pharmacy services, call HealthPlus at 800-332-9161 or Express Scripts at 877-322-8471.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. The Plan's drug formulary is based on the effectiveness and costs of drugs. Non-formulary drugs will be covered when prescribed by a Plan doctor. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a brand-name drug), but you request the brand-name drug, you pay the price difference between the generic and brand-name drug in addition to the generic copayment.
- **These are the dispensing limitations.** Prescription drugs covered by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for a 34-day supply. You pay a $10 copay per prescription for generic drugs or a $20 copay per prescription for brand-name drugs. Prescription drugs covered by a Plan or referral doctor and obtained through Express Scripts, or through the "Ask for 90 Rx" program, at a participating retail pharmacy may be dispensed for up to a 90-day supply, for which you will pay two times the normal copayment per prescription (i.e.: $20 for a 90-day supply of generic drugs, and $40 for a 90-day supply of brand name drugs). If no generic equivalent is available, you will still be required to pay the brand-name copayment.
- **"ASK for 90 Rx"** is a voluntary program developed by HealthPlus where you may choose to get a 90-day supply of a long-term medication with copay savings at participating retail pharmacies. Previously, this option was only available through the Express Scripts mail order prescription service. A few items to note:
  - Most pharmacies participate with the "Ask for 90 Rx" program. If you need assistance finding a pharmacy, please call Customer Service at 800-332-9161.
  - You may still receive a 90-day supply of oral contraceptives and patches for one copay.
  - Insulin, glucagon and EpiPens are available in the "Ask for 90 Rx" program.
  - Prescription compounds and specialty drugs or injectables are excluded from the "Ask for 90 Rx" program.
  - You can fill prescriptions for quantity-limited drugs, such as erectile dysfunction or migraine medications on "Ask for 90 Rx" program. The limit will be based on the number of days in the refill.
  - Prescriptions filled for 90 days are subject to prior authorization and all the usual prescription restrictions and exclusions in this brochure.
  - It is not medically appropriate to fill all drugs in a 90-day quantity. Your physician is the health care professional who will determine what is best.

- **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 that these drugs meet the same standards of quality and strength as brand-name drugs. Using the most cost-effective medication saves money. However, you and your physician have the option to request a brand-name even if a generic option is available. You will have to pay the difference between the cost of the generic and the brand-name drug in addition to the generic copayment.
- **When you have to file a claim.** Our members may occasionally receive bills for health care services. This could occur for a number of reasons, such as computer errors or out-of-area emergency treatment. If you receive a bill or statement, or are requesting reimbursement, mail the bills to us within 90 days of the date of service. Please be sure that the bill contains the following information:
  - Patient name
  - Subscriber number and the patient's two-digit relationship code as shown on your identification card (for example: 345123789-**01**)
  - Amount billed
  - Amount paid
  - Description of service and procedure codes
  - Diagnosis and diagnosis codes
  - Location of service
  - Date of service

Address the envelope as follows:

HealthPlus of MichiganAttention: Claims DepartmentP. O. Box 1700Flint, MI 48501-1700

You may download a Request for Reimbursement Form from our website at www.healthplus.org

If you need further assistance, or have questions, please call our Customer Service Department at 800-332-9161

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Full range of FDA-approved drugs, prescriptions, and devices for birth control • Insulin and insulin syringes • Diabetic testing reagents and supplies, including glucose test strips, test tape, and alcohol swabs • Smoking cessation drugs and medications; limited to one course of therapy every two years when prescribed by the Plan doctor or psychiatrist and accompanied by enrollment in a smoking cessation program approved by the Plan doctor or psychiatrist • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see next page)	**Retail Pharmacy** $10 per generic drug $20 per brand-name drug **"ASK for 90 Rx" (See page 46 for details.)** $20 per generic drug $40 per brand-name drug **Mail Order (35-90 day supply)** $20 per generic drug $40 per brand-name drug

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• Intravenous fluids and medication for home use, and some injectable drugs are covered under medical and surgical benefits. • Fertility drugs (when used in conjunction with prior authorized treatment plan) • Growth hormone	**Retail Pharmacy** $10 per generic drug $20 per brand-name drug **"ASK for 90 Rx" (See page 46 for details.)** $20 per generic drug $40 per brand-name drug **Mail Order (35-90 day supply)** $20 per generic drug $40 per brand-name drug
Here are some things to keep in mind about our prescription drug program: Benefits for Prescription Drugs in our formulary will be limited to the reasonable cost of generically available products, unless no generically equivalent product exists or a Member-specific review for medical necessity by us determines the need for brand name medication. We reserve the right to determine generic equivalency of products available to HPM Members. We reserve the right to review Prescription Drug products and procedures for medical necessity, efficacy of use, and quality to determine if they should be available to HPM Members. Visit our website at www.healthplus.org for more information on our Prescription Drug coverage.	
• Prescription Drugs for Treatment of sexual dysfunction: Coverage is limited to **fifty percent** (50%) of covered charges and will not exceed six (6) doses per thirty (30) day period and will be limited to the original prescription and up to two (2) refills prior to follow up with the treating physician.	50% per unit or refill
Not covered: • Drugs and supplies for cosmetic purposes • Vitamins, nutrients and food supplements even if a physician prescribes or administers them • Nonprescription medicines (or their prescription drug equivalents) • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies • Medical supplies such as dressings and antiseptics • *Drugs to enhance athletic performance* • *Replacement of lost, stolen, or destroyed medication*	*All charges*

Section 5(g). Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- 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 Desription	You Pay
Accidental injury benefit	**High 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.
Dental benefits	**High Option**
We have no other dental benefits.	*All charges*

Section 5(h). Special features

Feature	Description
NCQA "Excellent" accreditation	We have been awarded "Excellent" Accreditation status for our Commercial HMO – the highest level possible by the National Committee for Quality Assurance (NCQA). NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's health care.
High risk pregnancies	A case manager is assigned upon notification of a high risk pregnancy. The physician, member, and case manager develop a treatment plan specific to the member's medical needs.
Disease management program	If you have diabetes, asthma or certain heart diseases, you may be eligible to participate in our Disease Management Program. The program is designed to help you better understand and manage your condition, so you can enjoy improved health and quality of life. Ask your physician to refer you, or contact us at (800) 332-9161 for more information.
EyeMed Vision Discount Program	The EyeMed Vision Discount Program is included with your FEHB benefit at no additional cost. You and your covered dependents are eligible for immediate savings on eye care services when you use EyeMed participating providers. Just show your HealthPlus I.D. card at the time of service to save on eye exams, frames, lenses, contacts, and laser vision correction. For more information, or for help finding a participating provider, call EyeMed Vision Care, at 866-559-5252 (weekdays 9-9 and Saturdays 9-5), or visit them on the web at www.eyemedvisioncare.com. The HealthPlus discount group code is: 9232810.
Centers of excellence for transplants/heart surgery/ etc.	The following are Centers of excellence available when appropriately referred: • Cleveland Clinic Foundation • University of Michigan
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • 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 except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension ofthe time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
College students	Eligible college students are covered for emergency illnesses or injuries that occur when they are out of the service area. Contact us at (800) 332-9161 for eligibility requirements.

HealthQuest wellness and prevention programs	HealthPlus HealthQuest offers many educational programs to keep our members healthy and to engage members to improve their health if they wish to participate. In summary, HealthPlus HealthQuest offers the following programs: **HealthQuest Tobacco Cessation Program**:Designed to help you find a way that is best for you to quit smoking and stay smoke free. HealthPlus offers members a variety of resources and services free-of-charge when you are ready to quit. The program has many options to choose from, including: • **Quit Kit**: A free self-directed kit that deals with the behaviors associated with quitting. Support materials included guide you through the quitting process. • **Community Classes**: A listing of classes taught in the community. HealthPlus will reimburse at the completion of the course with an original receipt and certificate of completion. • **Phone Counseling**: Free phone counseling in which trained health coaches will work with you over the phone to identify a personalized cessation method that focuses on behavioral and lifestyles issues. Members may also elect to do program online with the phone coach or to do online exclusively. Once you signup for phone counseling , you will also receive a quit kit in the mail and have the option to receive e-mails and/ or participate in a web-based support program. If you think telephone counseling is right for you, enroll by calling 1-800-345-9956, ext 1943 or by visiting www.quitnet. com/healthplus. • **Prescription Benefits** **HealthQuest Weight Management Program**: Designed to help you manage your weight and improve your lifestyle. HealthPlus offers members a variety of resources and services free-of-charge. The program has many options to choose from, including: • **iCanChange Online Coaching**:Available to HealthPlus HMO members who are looking for help losing weight. Members will be assigned a personal health coach that will assist them in their weight management efforts online. To get registered: Members can call 1-800-345-9956, extension 1943, option 3 or email hquest@healthplus.org (including your name and member number). • **iCanChange Phone Coaching**:Available to HealthPlus HMO members whose weight puts them at risk for developing disease and may already have chronic health conditions such as high blood pressure and/or diabetes. This 12 month program is designed to give members the advantage of the iCanChange online coaching as well as phone coaching and an iCanChange kit that includes a workbook, pedometer and measuring tape. Members will be assigned to a personal health coach that will motivate and help them with weight management for one year! Members must meet risk requirements to qualify for this program. To get registered: call 1-800-345-9956, extension 1943, option 3. Or email hquest@healthplus.org (including your name and member number) • **HealthQuest Rewards**: All HealthPlus members can take advantage of HealthQuest Rewards. Some of the Rewards include: - **Diet Workshop**:Learn "The 7 Keys to Healthy Weight Management" - Attitude Awareness, Commitment, Planning, Food Choices, Food Portions and Exercise. The Diet Workshop offers classes in a variety of locations. Registration is $10 and $8 per week thereafter. - **Jenny Craig**:HealthPlus and Jenny Craig have teamed up to assist you by offering a free 30 day introductory program and discounts on both their 6 month and 12 month programs.

- **Weight Watchers**:HealthPlus members are eligible to receive special savings. Great rates are available on three proven weight management plans: Weight Watchers Local Meetings, Weight Watchers Online and Weight Watchers At Home. And, as an added incentive, HealthPlus will reward its members for participating in the weight management offering of their choice! Simply complete 10 weeks of your Weight Watchers plan and HealthPlus will reimburse half of your cost (a maximum reimbursement of $83)!
- **GlobalFit**:GlobalFit is a benefit that is offered to all HealthPlus members. GlobalFit makes it easy and affordable to join a fitness club by providing up to 60% off regular club rates and month-to-month memberships at over 10,000 quality fitness clubs nationwide.
- **HealthQuest Health & Wellness Online**:With HealthPlus, you can take advantage of our year-round program that offers a variety of wellness activities to help you feel great, boost energy and learn more about your health. Whether you are in good health or need a plan to get started, these wellness activities will help improve your quality of life. HealthQuest Health & Wellness Online benefits and features include:

- **Your Health**- Assess your own health by completing the HealthQuest Profile, develop your own personal wellness page based on your health risks and interests, then design your personalized health management plan.
- **Healthy Living Programs**- After assessing your health, you will be encouraged to participate in any of the 13 online healthy living programs. These six-week programs will help you reach your health goals at your own pace.
- **Health Challenges** - HealthQuest challenges you to improve your health by offering up to four online challenges a year!
- **Personal Health Record**- Record and manage your health history and your family members' health history in a personal health record that's completely confidential, secure and easy to access and share with your physician.
- **Daily Health News** - Features the most relevant and current health headlines.
- **Medical Resources** - Men, women, children and older adults can find information regarding common health issues to improve their health.
- **Health Encyclopedia** - Simple, free access to information on over 3,000 health topics on disease, drug information, health news, recipes and more!
- **Habitracker** - Record your daily activities, nutrition choices and body data.
- **Interactive Tools** - Check out the virtual trainer, sandwich maker, calculators and health quizzes designed to help you improve your health.

HealthQuest Health Information Phone Line:You can call HealthPlus to request any type of health information. The line is set up with nine different options of specific topics, such as lead testing, tobacco cessation and more. Simply call our toll free number, 1-800-345-9956, extension 1943 and select the information topic you need assistance with and we will follow-up with you to get you the information you need.

HealthQuest Monthly Employee Newsletters: HealthPlus will distribute a monthly two-page electronic health newsletter to all employees. This colorful newsletter provides current and timely health risk and healthy lifestyle information in an easy to read, informative format. Members can access the information through their Personal Health Page at www.healthplus.org, then selecting the Health & Lifestyle Link.

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 800-332-9161.

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

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

Submit your claims to: HealthPlus of Michigan
Attn: Claims
2050 S. Linden Rd.
P.O. Box 1700
Flint, MI 48501-1700

Important Note: Charges for the completion of claim forms, interest on late payments, or charges for failure to keep scheduled appointments are not covered.

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:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: 2050 South Linden Road, P. O. Box 1700, Flint, MI 48501-1700; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630 Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-332-9161 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member 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 (HealthPlus of Michigan) 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. Your care must continue to be authorized by your Plan PCP, or precertified as required.

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

We will not waive any of our out-of-pocket costs.

Claims process when you have the Original Medicare Plan – You probably do 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 800-332-9161 or see our Web site at www.healthplus.org.

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

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive Part B deductible, 20% of Medicare approved amounts and Part B excess charges. You will only be responsible for your member copyaments.

- **Medicare Advantage (Part C)**

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

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

This Plan and our Medicare Advantage plan:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
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	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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 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

Acute care service	The provision of highly concentrated care to patients requiring comprehensive observation, continuous monitoring, and treatment with immediate Physician intervention when necessary due to the seriousness or unstable nature of the illness or injury.
Affiliated provider	A provider who has agreed in writing to provide services to Members.
Appropriately referred	That situation when a referral is issued on behalf of a Member from that Member's Primary Care Physician to another Provider, or from a Physician to whom a Member is referred to another Provider, if such referrals are consistent with the Plan's referral policy.
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 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	Short term, Non-skilled care, furnished for the purpose of meeting non-medically necessary personal needs, such as assistance in walking, dressing, bathing, eating and taking medications. Custodial care lasting 90 days or more is sometimes known as Long term care, neither of which are covered by this Plan.
Day treatment mental health and/or substance abuse services	Generally accepted therapeutic services and/or ancillary services which last four (4) or more consecutive days.
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.
Dental care	Services or procedures which concern maintenance or repair of the teeth and/or gums or are performed to prepare the mouth for dentures.
Dentist	An individual licensed under the Act or any licensing statute or law of the applicable governing state or governmental unit to engage in the practice of dentistry.
Durable medical equipment	Equipment of the type approved by the Plan which is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness or injury.
Experimental or investigational services	A service that is of doubtful medical usefulness or effectiveness to the Member, as assessed by local medical community standards.
Freestanding emergency center	A Facility which is licensed, certified, or otherwise authorized pursuant to the Act or any similar licensing statute or law of its governing state or governmental unit to provide services in emergencies or after hours.
Hearing aid	An electronic device of the type approved by HPM worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mold, if medically necessary.

Home health agency	A facility or program which is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit and is approved to provide home health services.
Hospice	A Provider which is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit to supply pain relief, symptom management, and supportive services to individuals suffering from a disease or condition with a terminal prognosis.
Hospital	An acute care general facility which: (1) provides inpatient diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of duly licensed Physicians; (2) is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit; and (3) which is not, other than incidentally, a place of rest, a place for the aged, a nursing home, or a facility for the treatment of substance abuse or pulmonary tuberculosis.
In-network benefits	The provision of Covered Services by: (A) The Member's Primary Care Physician; (B) A Provider to whom the Member is Appropriately Referred; or (C) An Affiliated Provider when a referral or other authorization is not required by the Plan.
Intermediate care	As it applies to Mental Health and Substance Abuse Services, the use of a full or partial residential therapy setting (also known as Residential and Day Treatment programs), and shall include generally accepted therapeutic techniques and other therapeutic and ancillary services.
Intermittent skilled nursing care	Services provided by a licensed nurse to a Member who has a medically predictable recurring need for skilled care at least once in every sixty (60) day period.
Medical necessity	The health care associated with the Member is consistent with and called for in relationship to the intensity of service, severity of illness, and appropriateness of services provided.
Medicare	Title XVIII of the Social Security Act and all amendments thereto.
Members	The Subscriber and his/her Dependents covered under this Contract.
Non-affiliated provider	A Provider who has not agreed in writing to provide services to Members.
Non-plan physician	A Physician who has not entered into a written contract to provide services to Members.
Non-preferred mental health provider	An Affiliated Provider specializing in the treatment of mental illness who is not designated by the Plan as a Preferred Provider.
Non-preferred substance abuse provider	An Affiliated Provider specializing in the treatment of substance abuse who is not designated by the Plan as a Preferred Provider.
Orthotic appliance	An apparatus of the type approved by the Plan which is used to support, align, prevent, or correct deformities, or to improve the function of movable parts of the body.
Out-of-network benefits	The provision of Covered Services by: (A) A Non-Affiliated Provider, unless Appropriately Referred; (B) An Affiliated Provider (other than the Member's Primary Care Physician) to whom the Member was not Appropriately Referred; or (C) A Provider under any other circumstances which does not meet the definition of an In-Network Benefit.
Outpatient mental health and/or substance abuse services	Therapeutic services which last less than (4) consecutive hours.
Pharmacy	A business licensed under the Act or similar licensing statute or law of its governing state or governmental unit to engage in the practice of pharmacy.

Physician	An individual licensed under the Act or other similar licensing statute or law of the applicable governing state or governmental unit to engage in the practice of allopathic medicine, osteopathic medicine, chiropractic, or podiatric medicine and surgery.
Plan physician	Any Physician who has entered into a written contract to provide services to Members.
Preferred mental health provider	An Affiliated Provider specializing in the treatment of mental illness who is both selected by a Member for his/her care and is designated by the Plan as a Preferred Mental Health Provider.
Preferred substance abuse provider	An Affiliated Provider specializing in the treatment of substance abuse who is both selected by a Member for his/her care and is designated by the Plan as a Preferred Substance Abuse Provider.
Prosthetic device	A device that replaces all or a part of an internal body organ or external body member, or that replaces all or a part of the function of a permanently inoperative or malfunctioning internal body organ or external body member.
Provider	A health professional, facility, or agency complying with the Act or other similar licensing statute of the applicable governing state or governmental unit. The following services are not covered: Services which are provided by individuals who are not licensed/certified under the Michigan Public Health Code (or other similar code/statute of any other state or government unit) or services which are beyond the treating individual's licensing.
Reasonable charge	The lesser of the treating Provider's charge or the amount determined to be a fair charge by the Plan in comparison to charges of other Providers in the same geographic region.
Residential substance abuse program	A course of treatment which requires twenty-four (24) hour on-site presence coupled with the continuous availability of intense drug and alcohol therapy.
Semi-private room	A room containing two (2) or more patient beds in an inpatient facility.
Short-term	Service for a condition which the Plan determines can be expected to significantly improve within a period of sixty (60) days.
Skilled care service	Concentrated observation, monitoring, evaluation, and intervention by licensed and trained personnel under the direction of a Physician and usually does not require daily intervention for conditions that are stable or stabilizing.
Skilled nursing facility	A facility licensed to provide Skilled Nursing Care in accordance with the Act or other similar licensing statute of its governing state or governmental unit.
Specialist physician	A Plan or Non-Plan Physician to whom a Member is Appropriately Referred.
Us/We	Us and We refer to HealthPlus of Michigan.
Visit	A meeting between a Member and Provider for the purpose of rendering Covered Services, without regard to the frequency of meetings if each such meeting is separated by any period of time.
You	You refers to the enrollee and each covered family member.

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

- See www.opm.gov/insure/health for enrollment information as well as:
- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

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

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

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

Types of coverage available for you and your family

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when 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, divorce, 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 2009 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 2008 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 for 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 Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary BEFORE taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **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) –**Reimburses you 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 any other insurance.
- **Dependent Care FSA (DCFSA) –** Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

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 Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans will provide a comprehensive range of services, including all 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.

Additional Information

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

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).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurace 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). Certain medical conditions, or combinations or conditions, will prevent some people from being approved for coverage. 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.

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

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Notes

Notes

2009 Summary of benefits for HealthPlus of Michigan

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

Benefits	You pay	Page
Medical services provided by physicians:		
• **Diagnostic and treatment services provided in the office**	Office visit copay: $10 primary care; $20 specialist	17
Services provided by a hospital:		
• **Inpatient**	Nothing	39
• **Outpatient**	Nothing	40
Emergency benefits:		
• **In-area or out-of-area**	• $10 per office visit • $25 per urgent care center visit • $75 per hospital visit	44
Mental health and substance abuse treatment:	Regular cost sharing	45
Prescription drugs:		47
• Retail pharmacy	$10 generic/$20 brand-name	
• "ASK for 90 Rx"(See page 46.)	$20 per generic/$40 brand-name	
• Mail order (35 to 90 day supply)	$20 generic/$40 brand-name	
Dental care (Accidental injury benefit only)	Nothing	50
Vision care	No benefit.	
Special features: · · NCQA "Excellent" Accreditation · High risk pregnancies · Disease management program · EyeMed vision discount program · Centers of Excellence for transplants/ heart surgery, etc. · Flexible benefits option · College students · HealthQuest and Health resource library		51
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	We have no out-of-pocket maximum. Your out-of-pocket expenses covered under this plan are limited to stated copayments that are required for a few benefits.	13

2009 Rate Information for HealthPlus of Michigan

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 rates apply to career Postal Service employess. Most employees should refer to the Guide to Benefits *for Career* United States Postal Service Employees, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2NU). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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	USPS Share	Your Share
East Central Michigan							
High Option Self Only	X51	155.66	64.28	337.26	139.28	179.45	40.49
High Option Self and Family	X52	352.56	149.00	763.88	322.83	406.42	95.14