Health Alliance HMO

www.healthalliance.org

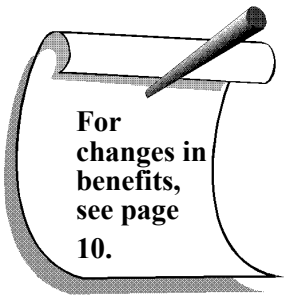
Health Alliance

2012

A Health Maintenance Organization High Option Plan

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

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See Page 9 for requirements.



This plan has an excellent accreditation for Commercial PPO and HMO plans

Enrollment codes for this Plan:

FX1 High Option Self Only
FX2 High Option Self and Family

Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-168

Important Notice from Health Alliance Medical Plans, Inc.

About Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 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 (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

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Introduction

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

Health Alliance HMO
301 S Vine Street
Urbana, IL 61801

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012 and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanation of benefits (EOBs) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-800-851-3379 and explain the situation.

-If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include,falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly by your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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.
- 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.

Patient Safety Links

- www.ahrq.org/consumer- 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.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital- acquired conditions or for inpatient services needed to correct Never Events, if you use Health Alliance HMO Plan providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that may occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood or hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

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 our most recent provider directory. You can also view our provider directory at our website www.healthalliance.org.

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

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

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

Questions regarding what protections apply, and what might cause a plan to change status from grandfathered to non-grandfathered may be directed to us at 1-800-851-3379. You can also read additional information from the U.S. Department of Health and Human Services at www.healthreform.gov.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same(i.e. the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

As a non-grandfathered health plan, this plan has also decided to follow the requirements that apply to grandfathered plans.

Questions regarding what protections apply may be directed to us a 1-800-851-3379. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our High Option

The high option plan offers coverage with no deductibles. You are responsible for copayments and coinsurance.

How we pay providers

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

Your Rights

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

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

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

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

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

Your medical and claims records are confidential

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

Service Area

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

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

Our Illinois service areas are:

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

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

East Central Illinois Service Area: *Illinois Counties:* Champaign, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Effingham, Fayette, Ford, Grundy, Iroquois, Jasper, Kankakee, Kendall, LaSalle, Livingston, McLean, Moultrie, Piatt, Shelby, Tazewell, Vermilion, Will and Woodford; *Indiana Counties:* Fountain, Vermillion and Warren

East St. Louis Service Area: *Illinois Counties:* Bond, Calhoun, Clinton and Monroe

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

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

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

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

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

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

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

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

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

Our Iowa service area is:

Central and Eastern Iowa Service Area: *Iowa Counties:* Benton, Blackhawk, Boone, Bremer, Butler, Calhoun, Carroll, Cedar, Clinton, Dallas, Delaware, Fayette, Greene, Grundy, Guthrie, Hamilton, Hardin, Humboldt, Jasper, Johnson, Jones, Keokuk, Linn, Louisa, Madison, Marshall, Muscatine, Polk, Poweshiek, Sac, Story, Tama, Warren, Washington, Webster and Wright

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

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

Section 2. How we change for 2012

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

Program Changes:

- Sections 3, 7, and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to the High Option Plan:

- The East Central service area has expanded to now include the following counties: Kankakee and Will.
- A East St. Louis service area has been added to include the following counties: Bond, Calhoun, Clinton and Monroe counties.
- The Dekalb service area has expanded to now include Kane county.
- The Peoria service area has expanded to now include Fulton county.
- The inpatient hospital admission copayment is decreasing to $200 per day, up to an increased maximum of $1000 per admission.
- The emergency services/accidents copayment is increasing to $200 per emergency room visit.
- The inpatient mental health and substance abuse treatment copayment is decreasing to $200 per day, up to an increased maximum of $1000 per admission.
- The outpatient surgery copayment is increasing to $250 per outpatient surgical admission.
- Your share of the non-Postal premium will increase for the Self Only and for the Self and Family. See page 73.

Section 3. How you get care

Identification cards

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

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

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a Primary Care Physician. This decision is important since your Primary Care Physician provides or arranges for most of your health care.

- **Primary care**

Your Primary Care Physician can be a family practitioner, internist or pediatrician.Your Primary Care Physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change Primary Care Physicians or if your Primary Care Physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your Primary Care Physician will refer you to a specialist for needed care. When you receive a referral from your Primary Care Physician, you must return to the Primary Care Physician after the consultation, unless your Primary Care Physician authorized a certain number of visits without additional referrals. The Primary Care Physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your Primary Care Physician gives you a referral. However, you may receive optometric care for routine eye exams and females may see a Woman's Principal Health Care Provider without a referral. You are responsible for making sure your Primary Care Physician refers you to an in-network specialist. Please refer to your provider directory or you can view our provider directory on our website at www.healthalliance.org.

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

- If you need to see a specialist frequently because of a chronic, complex or serious medical condition, your Primary Care Physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your Primary Care Physician will create your treatment plan. The phyiscian may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. 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.

- **Continuity of Care**

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 you specialists based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

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

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

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

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

- you are discharged, not merely moved to an alternative care center;
- 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.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

Precertification is the process by which- prior to your inpatient hospital admission- we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

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

- Transplants

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you or your representative, must call us at 1-800-851-3379 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital that number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the recept of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim(i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treat), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, you representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care** — You do not need to preauthorize your normal delivery at a Plan provider. Your Plan Primary Care Physician or specialist will make necessary hospital arrangements and supervise your care.
- **If your treatment needs to be extended** — If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we received the claim.

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

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

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim** — Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

  1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
  2. Ask you or your provider for more information.

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

  If we do not received 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.

  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim** — In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM** — After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

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

Copayments

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

Example: When you see your Primary Care Physician, you pay a copayment of $20 per office visit and when you go in the hospital, you pay $200 per day.

Cost-Sharing

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

Coinsurance

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

Example: You pay 20% of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum

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

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

You have a separate out-of-pocket maximum for specialty prescription drugs of $1,500 per person or $3,000 per family. See Section 5(f) for specific information on coverage of specialty prescription drugs.

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

Carryover

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

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

When Government facilities bill us

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

High Option Benefits

See page 10 for how our benefits changed this year. Pages 19-49 are benefit summaries for the High Option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High Option Benefits Overview

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

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

The High Option Plan benefit features include:

- $20 copayment per office visit to a Primary Care Physician.
- $30 copayment per office visit to a Specialist.
- $200 copayment per day, up to a maximum of $1000 per inpatient admission.
- $250 copayment per outpatient surgical admission.
- $200 copayment per emergency room visit.
- $15/$30/$50 copayments on Tiers 1, 2 or 3 for a 30-day supply of prescription drugs.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office	$20 per office visit to a Primary Care Physician. $30 per office visit to a Specialist.
Professional services of physicians • In an urgent care center • Office medical consultation • Second surgical opinion	$20 per office visit to a Primary Care Physician. $30 per office visit to a Specialist.
Professional services of physicians • During a hospital stay • In a skilled-nursing facility	Nothing if you are an inpatient in a hospital or skilled nursing facility. You pay only your hospital admission or skilled nursing facility copayment.
At home	$20 per Primary Care Physician visit $30 per Specialist visit
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. You pay only your office visit copayment.

Benefit Description	You pay
Preventive care, adult	**High Option**
Routine physical every year which includes: Routine screenings, such as: • Total Blood Cholesterol - once every three years. This includes fasting lipoprotein profle for cholesterol/lipid screening. • Colorectal Cancer Screening, including - Fecal occult blood test - Double contrast barium enema – every five years starting at age 50	Nothing.
• Colorectal cancer screening, including - Sigmoidoscopy, screening - every five years starting at age 50 - Colonoscopy - every 10 years starting at age 50	Nothing.
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing.
Routine Pap test	Nothing.
Routine mammogram-covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing.
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC).	Nothing.
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending camp, or travel.	*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 • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations	Nothing.

Benefit Description	You pay
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 preauthorize your normal delivery; see page 14 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	Nothing for prenatal care or the first postpartum care visit; $30 per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services.
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 Note: We cover oral contraceptives under the prescription drug benefit.	Nothing. You pay only your office visit copayment.
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges.*

Benefit Description	You pay
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) Note: Fertility drugs, including injectables, specialty prescription drugs and oral fertility drugs, are paid under the prescription drug benefit; see Section 5(f) Prescription Drug Benefits. Note: Approval of infertility services must follow the Plan medical policy (see page 13).	$20 per office visit to a Primary Care Physician. $30 per office visit to a Specialist. $250 copayment per outpatient surgical admission
Not covered: • *ART procedures not listed in the section above* • *Non-medical cost of donor sperm* • *Non-medical cost of donor egg* • *Infertility service after voluntary sterilization*	*All charges.*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	$20 per office visit to a Primary Care Physician. $30 per office visit to 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 30. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	$20 per office visit to a Primary Care Physician. $30 per office visit to a Specialist. Nothing per visit during a covered inpatient admission. IV or oral specialty drugs are covered under the specialty prescription drug benefit. See page 46.

Benefit Description	You pay
Physical and occupational therapies	**High Option**
A combined total of 60 visits per condition per calendar year for the outpatient services of each of the following: • qualified physical therapists • 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. Inpatient rehabilitation services are covered under the Extended care benefits/skilled nursing facility benefits/rehabilitation benefits heading of Section 5 (c). Services provided by a hospital or other facility, and ambulance services on pages 36-38.	$30 per office/outpatient visit. Nothing per visit during a covered inpatient admission.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Phase III cardiac rehabilitation*	*All charges.*
Speech therapy	**High Option**
• 60 visits per condition per calendar year	$30 per office/outpatient visit. Nothing per visit during covered inpatient admission.
Hearing services (testing, treatment, and supplies)	**High Option**
• External hearing aids	All charges over the $750 maximum benefit for hearing aids/ devices every three years.
• Screening and testing services for hearing aids	All charges over the $100 maximum benefit for screening and testing services for a hearing aid every three years.
Not covered: *Hearing services that are not shown as covered*	
Vision services (testing, treatment, and supplies)	**High Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions and exams Note: See *Preventive care, children* for eye exams for children.	$30 per vision exam
Not covered: • *Eyeglasses or contact lenses, and contact lens fittings except as shown above*	*All charges.*

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

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	**High Option**
• *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	**High Option**
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts	$20 per office visit to a Primary Care Physician. $30 per office visit to 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**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Internal prosthetic devices, such as artificial joints, pacemakers and surgically implanted breast implant following mastectomy. • Custom molded foot orthotics • Lumbosacral supports Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	20% coinsurance.
Not covered: • *Orthopedic and corrective shoes(except for diabetic shoes when medical criteria is met)*, arch supports,heel pads, and feel cups	*All charges.*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**High Option**
• *Corsets, trusses, elastic stockings, support hose and other supportive devices* • *Prosthetic replacements provided less than five years after the last one we covered, unless it is irreparable and the member has properly maintained it.*	*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 • Insulin pumps • Audible prescription reading devices • Speech generating devices • Lancets Note: Call us at 1-800-851-3379 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% coinsurance.
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN) or home health aide • Services include oxygen therapy, intravenous therapy and medications	$20 per visit.
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*	*All charges.*

Benefit Description	You pay
Chiropractic	**High Option**
• Manipulation of the spine and extremities is covered if referred by the Primary Care Physician and approved by a medical director. • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy and cold pack application are covered as rehabilitative therapy services and are subject to 60 treatments per condition per calendar year. Hot/cold pack therapy used in conjunction with approved manipulation and mobilization is covered. X-rays and other diagnostic testing are covered under diagnostic and treatment services and must be provided by a Plan provider. Note: Spinal manipulations and mobilizations are covered when long-term significant improvement can be expected from such treatment.	$30 per office visit.
Alternative treatments	**High Option**
• Biofeedback - under certain circumstances	$20 per office visit to a Specialist.
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Acupuncture*	*All charges.*
Educational classes and programs	**High Option**
Coverage is provided for: • Diabetes self management training and education • Childhood Obesity Education	$20 per office visit to a Primary Care Physician. $30 per office visit to a Specialist. Nothing.
Tobacco cessation programs, including individual/group/telephone counseling, and for physician prescribed over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. • Health Alliance offers *I Can Quit,* a telephone-based tobacco cessation program. Interested members may call 1-866-345-5129 to determine their readiness to quit. If they are ready, they may enroll in the program and choose the level of telephone support they want from our trained health coaches. Enrollees will receive a free quit kit by mail. In addition, the member's health coach will follow up with the member and the member's physician throughout the year. Members are eligible to enroll in *I Can Quit* twice per 12 month period.	Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
• Enrollees may get nicotine replacement therapy (gum, lozenges or patches) or the option prescriptions drugs(Zyban®, prescription Chantix® or Bupropion (generic Zyban) for each quit attempt with no copayment. The plan will pay for 30 day supply at a time. These medications must be obtained by prescription.	Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
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) if medical criteria determined by the plan are met. See *Services requiring our approval* on page 13. • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation) (vasectomy only covered in a physician's office) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done.	$20 per office visit to a Primary Care Physician. $30 per office visit to a Specialist. Nothing if you are an inpatient in a hospital. You pay only your hospital admission copayment. Nothing if performed in an outpatient hospital setting or ambulatory surgical facility. You pay only your outpatient surgical facility copayment.
Not covered: • *Reversal of voluntary sterilization*	*All charges.*

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
• *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, webbed fingers and webbed 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 - 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.	$20 per office visit to a Primary Care Physician. $30 per office visit to a Specialist. Nothing if you are an inpatient in a hospital. You pay only your hospital admission copayment. Nothing if performed in an outpatient hospital setting or ambulatory surgical facility. You pay only your outpatient surgical facility copayment.
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*	*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	$20 per office visit to a Primary Care Physician. $30 per office visit to a Specialist. Nothing if you are an inpatient in a hospital. You pay only your hospital admission copayment. Nothing if performed in an outpatient hospital setting or ambulatory surgical facility. You pay only your outpatient surgical facility copayment.

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	**High Option**
• Other surgical procedures that do not involve the teeth or their supporting structures	$20 per office visit to a Primary Care Physician. $30 per office visit to a Specialist. Nothing if you are an inpatient in a hospital. You pay only your hospital admission copayment. Nothing if performed in an outpatient hospital setting or ambulatory surgical facility. You pay only your outpatient surgical facility copayment.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Lung: single/bilateral • Kidney • Liver • Pancreas • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas **Blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.	Nothing.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced Myeloproliferative Disorders (MPD's) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Hemoglobinopathy - Marrow failure and related disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for • Advanced Childhood kidney cancers • Advanced Ewing sarcoma • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Advanced neuroblastoma • Amyloidosis • Breast Cancer • Childhood rhabdomyosarcoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgkin lymphoma) • Multiple myeloma • Neuroblastoma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors.	
Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for - Multiple myeloma - Testicular, Mediastinal, Retroperitoneal and Ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer	Nothing.
Mini-transplants performed in a clinical trial setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy	Nothing.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Marrow failure and related disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic(i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing.
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma (de novo and treated) - AL Amyloidosis	Nothing.
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Heath **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. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for	Nothing.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes - Multiple myeloma	Nothing.
• Mini-transplants (nonmyeloablative allogeneic transplants or reduced intensity condition (RIC) for - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Myelodysplasia/Myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Autologous transplants for - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CSS/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Advanced Childhood Kidney cancers - Advanced Ewing sarcoma - Breast Cancer - Childhood rhabdomyosarcoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) • National Transplant Program (NTP)	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	Nothing.
Transportation, lodging and meals for the transplant recipient and a companion for travel to and from a Plan-designated center of excellence is covered. If the patient is a minor, transportation and reasonable and necessary lodging and meal costs for two persons who travel with the minor are included. Expenses for meals and lodging are reimbursed at the per diem rates established by the Internal Revenue Service.	Please contact Health Alliance at 1-800-851-3379 for the current per diem reimbursement rates.
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered* • *Experimental organ or tissue transplants*	*All charges.*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient)	Nothing. You pay only your hospital admission copayment.
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing if you are a patient in an outpatient hospital setting or ambulatory surgical facility. You pay only your outpatient surgical facility copayment.
Professional services provided in - • Office	Nothing. You pay only your office visit copayment.

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate or intensive care accommodations • General nursing care • Meals and special diet. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$200 copayment per day, up to a maximum of $1000 per admission.
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 • Dressings, splints, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Rehabilitative services	Nothing.
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*

Benefit Description	You pay
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.	$250 copayment per outpatient surgical admission.
Not covered: • *Blood and blood derivatives not replaced by the member*	*All charges.*
Extended care benefits/skilled nursing care facility benefits/rehabilitative services	**High Option**
Extended care benefit: Up to a combined total of 120 days per calendar year for rehabilitative therapy and skilled nursing care in an approved nursing facility. Rehabilitative services received in an acute inpatient setting apply toward the combined 120 days per calendar year.	Nothing for days 1-20. $75 copayment per day for days 21-120.
Not covered: • *Custodial care*	*All charges.*
Hospice care	**High Option**
Supportive and palliative care for terminally ill members is covered in the home or hospice facility. Services include inpatient or outpatient care and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately 12 months or less.	Nothing.
Not covered: • *Independent nursing, homemaker services*	*All charges.*

Benefit Description	You pay
Ambulance	**High Option**
Local professional ambulance service when medically appropriate	$100 copayment per occurrence for emergency ambulance transportation

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, call the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or your family member should notify the Plan within 48 hours after care begins unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified in a timely manner.

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

To be covered by this plan, follow-up care recommended by non-plan providers must be approved by the Plan or provided by Plan physicians.

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

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

To be covered by this Plan, follow-up care recommended by non-plan providers must be approved by the Plan or provided by Plan physicians.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: If admitted, the emergency room copayment is waived and you pay the appropriate inpatient hospital admission copayment.	$20 per primary care visit. $30 per specialty care visit. $20 per primary care visit. $30 per specialty care visit. $200 per emergency room visit.
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$20 per primary care visit. $30 per specialty care visit. $20 per primary care visit. $30 per specialty care visit. $200 per emergency room visit.
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	**High Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	$100 copayment per occurrence for emergency ambulance transportation

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

You need to get Plan approval(preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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.

Benefit Description	You pay
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alchoholism and drug abuse, including detoxification, treatment and counseling	$20 per office visit.

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**High Option**
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$20 per office visit.
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner. • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing.
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services. • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$200 copayment per day, up to a maximum of $1000 per admission
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility	See professional services or inpatient hospital or other covered facility benefits.
Not covered	**High Option**
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:

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

	A list of the Plan's mental health/substance abuse providers can be found in the Plan's provider directory for your service area or you may contact the Customer Service Department at 1-800-851-3379 to see which mental health/substance abuse providers participate with the Plan in your service area.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy or by mail order. For members who take maintenance medications, you have three choices. **Mail order prescriptions and Retail 90Rx are optional and available only to members who take maintenance medications**.
  - Choice 1: Get a 30-day supply of medications for one copayment at a local retail pharmacy. This is the same benefit available for one-time prescriptions.
  - Choice 2: Get 90 days of maintenance medication through mail order and receive a discount.
  - Choice 3: Get 90 days of maintenance medication at a local retail pharmacy and also receive a discount. You must take a prescription for a 90-day supply to a participating Retail 90Rx pharmacy or have your prescription transferred to a Retail 90Rx pharmacy.
- **Preferred Pharmacy discounts.** For select medications purchased for the treatment of asthma, diabetes, high blood pressure and high cholesterol; members will have a $0 copayment when these drugs are purchased at either a Preferred Pharmacy or a Preferred Plus Pharmacy. For more information regarding these select drugs please call 1-800-851-3379.
- **We use a formulary.** The Plan has a tiered pharmacy copayment structure for each 30-day supply. To keep your costs as low as possible, we ask that you and your physician select appropriate medicines from the list. We have an open formulary. However, the Plan recognizes the value of using FDA-approved generic drugs whenever medically appropriate. For this reason, you will always pay the lowest copayment for generic drugs. If your physician believes a brand-name product is necessary or there is no generic available, your physician may prescribe a brand-name drug from the formulary list. This list of brand-name drugs is a preferred list of drugs that we selected to meet your needs at a lower cost. When a generic drug doesn't't exist, brand-name drugs that are not on our preferred list require the highest copayment level. To order a prescription drug brochure, call 1-800-851-3379 or you can view our formulary on our website, www.healthalliance.org.
- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referring physician and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. Maintenance medication can be dispensed for up to a 90-day supply through mail order or at a pharmacy participating in Retail 90Rx.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure these drugs meet the same standards of quality and strength as brand-name drugs.
- **When you do have to file a claim.** If you have to pay out-of-pocket for a prescription because you do not have your ID Card, please contact our Customer Service Department at 1-800-851-3379 for information on submitting your claim.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Prescription drugs prescribed by a Plan or referring physician and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply or manufacturer's standard package. • Members who take maintenance medication and choose the options of mail order or Retail 90Rx at a participating pharmacy for a 90-day supply, will pay 2.75 copayments (instead of three copayments) for a 90-day supply. • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin and diabetic supplies including glucagon emergency kits, syringes and needles, oral legend agents for controlling blood sugar, and test strips for glucose monitors. • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction - Must be medically necessary - Member must be 18 years or older - Covered quantity limited to four tablets per 30-day period - Member cannot be on nitrates - No coverage for women • Prescription contraceptives • Some prescription drugs require preauthorization from a Plan medical director and certain criteria to be met by the member. The member's physician must contact the Plan to obtain preauthorization. To accord with changes in medical technology, the Plan maintains a list of pharmaceuticals that require preauthorization. The list is available to the member upon request. Failure to obtain preauthorization may result in the dispensing pharmacy requiring personal payment from the member.	At a Plan pharmacy per prescription unit or refill: $15 Tier 1 (mainly generic) $30 Tier 2 (brand-name on formulary) $50 Tier 3 (brand-name non-formulary) For members on maintenance medication that choose to use the options of mail order or Retail 90Rx, copayments are based on a 90-day supply. You pay 2.75 copayments for a 90-day supply: $41.25 Tier 1 $82.50 Tier 2 $137.50 Tier 3 Note: If there is no generic equivalent available, you will still have to pay the brand-name copayment. Note: If the physician allows substitution and the member prefers a brand-name drug on the formulary instead of the generic (if available), the member pays $15 plus the difference in cost between the generic and the brand-name drug. If the physician does not allow substitutions, the member will pay the brand name copayment.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• *Value-Based Benefit* - Members who take medication for asthma, high cholesterol, high blood pressure or diabetes may receive discounted copayments for select prescriptions. Medications that are available at the discounted copayment are noted on the Prescription Drug Formulary on our website at www.healthalliance.org or you can contact our Pharmacy Customer Service at 1-800-851-3379, ext. 8078.	All generic drugs - Tier 1 copayment. All other specified prescription drugs or supplies available under the value-based benefit - no more than 10% coinsurance up to a maximum of $20.
• Specialty Prescription Drugs Some Specialty Prescription Drugs are covered when provided by a Participating Provider. Coverage is subject to prior written order by your Physician and Preauthorization by a Medical Director. To be consistent with changes in medical technology, Health Alliance will maintain a list of covered Specialty Prescription Drugs and the medical conditions for which they are approved for coverage. Examples of Specialty Prescription Drugs include: Interferons, Erythropoietin and granuloctye colony stimulating factor (G-CSF). Specialty Prescription Drugs must be purchased through Walgreens, either through the mail or local retail store and are limited to a 30-day supply. Coverage can be verified by calling the Customer Services Department at 1-800-851-3379. Growth hormone therapy (GHT) - Note: We will only cover GHT when we preauthorize treatment. Call 1-800-851-3379 for preauthorziation. We will ask you to submit information that established the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3.	20% Coinsurance. Out-of-pocket maximum per calendar year: $1,500 per member $3,000 per family
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-plan pharmacy, except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Non-prescription medicines* • *Drugs for which there is a non-prescription equivalent available*	*All charges.*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• *Medical supplies, such as dressings & antiseptics* *Note: Physician prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the tobacco cessation benefit. (See page 27)*	*All charges.*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

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

Benefit Description	You Pay
Accidental injury benefit	**High Option**
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 benefit	**High Option**
We have no other dental benefits.	

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract 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 in addition to other terms as necessary. 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 do not 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 of the time period, but regular contract 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. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Services for deaf and hearing impaired	TTY 711 or 1-800-526-0844 (Illinois Relay)
Reciprocity benefit	The Plan offers a reciprocity program for family members living temporarily away from home in an area serviced by the Plan. Under this program, family members living away can receive coverage for medically necessary routine care. For additional information on this program, or to enroll a family member, call the Customer Service Department at 1-800-851-3379.

Non-FEHB benefits available to Plan members

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

Medicare prepaid plan enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 60, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to suspend their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join the Medicare prepaid plan, but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits, and if so, what you will have to pay. Contact your retirement system for information on suspending your FEHB enrollment and changing to a Medicare prepaid plan. Contact the Plan at 1-800-965-4022 for information on the Medicare prepaid plan and the cost of that enrollment.

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

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

Section 7. Filing a claim for covered services

This section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, received services are Plan hospitals and facilities, or obtain your prescription drugs as Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

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 CMS 1500, Health Insurance Claim Form. Your facility will file on the UB 04 form. For claims questions and assistance, contact us at 1-800-851-3379, or at our Web site at www.healthalliance.org.

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

- Covered member's name, date of birth, address, phone number 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 payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Health Alliance Medical Plans, Inc.

301 S. Vine Street

Urbana, IL 61801

Prescription drugs

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

Deadline for filing your claim

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

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. if matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 45 days from the receipt of the notice to provide the information.

if you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

You may be able to appeal to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.healthalliance.org.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). If Section 3 If you disagree with our pre-service claim decision, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claims.

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: Health Alliance Medical Plans, 301 South Vine Street, Urbana, IL 61801; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision quicker. We will provide you , free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claims decision. We will provide you with this information sufficiently in advance of the date we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. 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.
3	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, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E. Street, NW, Washington, DC 20415-3620.

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 benefit (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.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

4 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 you did not indicate that your claim was a claim for urgent care, then call us at 1-800-851-3379. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

When we are the secondary payor, 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
- 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 (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you did not take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You can also sign up at any time while you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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

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

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-851-3379.

We waive some costs if the Original Medicare Plan is your primary payor – If you are enrolled in the High Option plan, we will waive some out-of-pocket costs as follows:

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

You can find more information about how our plan coordinates benefits with Medicare by calling the Customer Service Department at 1-800-851-3379.

- **Tell us about your Medicare Coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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), (TTY 1-877-486-2048) or at www.medicare.gov.

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

  This Plan and our Medicare Advantage plan: You may enroll in one of our Medicare Advantage plans and also remain enrolled in our FEHB plan. In this case, we do waive some cost sharing for your FEHB coverage.

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

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

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

  When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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 Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor 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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor 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 (or a covered family member) 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 a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

If you are a participant in a Clinical Trial, this health plan will provide related care as follows, if it is not provided by the Clinical Trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.

- Extra care costs - costs related to taking part in a Clinical Trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan covers some of these costs, providing the Plan determines the services are medically necessary. For more specific information see Page 32. We encourage you to contact the Plan to discuss specific services if you participate in a Clinical Trial.
- Research costs - costs related to conducting the Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the Clinical Trials and this Plan does not cover these costs.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a Clinical Trial or is receiving standard therapy
- Extra care costs - costs related to taking part in a Clinical Trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs - costs related to conducting the Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 14.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 14.

Cost-sharing

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

Covered services

Care we provide benefits for, as described in this brochure.

Custodial Care

Custodial care means services designed to help beneficiaries meet the needs of daily living whether they are disabled or not. These services include help in: a) walking or getting in and out of bed; b) personal care such as bathing, dressing, eating or preparing special diets; and/or c) taking medication that the beneficiary would normally be able to take without help. Custodial care that lasts 90 days or more is sometimes known as long-term care.

Experimental or investigational service

The Plan considers factors which it determines to be most relevant under the circumstances, such as published reports and articles in the authoritative medical, scientific and peer review literature or written protocols used by the treating facility or being used by another facility studying essentially the same drug, device or medical treatment. This Plan also considers federal and other government agency approval as essential to the treatment of an injury or illness by, but not limited to, the following: American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, the Food and Drug Administration or the National Institutes of Health.

Group health coverage

Any group arrangement that provides a member with hospital, medical, surgical or dental benefits and that consists of employer-sponsored group insurance, association-sponsored group prepayment coverage, coverage under labor-management trusteed plans, employer organization plans or employee benefit organizations.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

A service or supply that is required to identify or treat a condition and is:

- Appropriate and necessary for, and consistent with, the symptom or diagnosis and treatment or distinct improvement of an illness or injury.
- Adequate and essential for the evaluation or treatment of a disease, condition or illness.
- Can reasonably be expected to improve the member’s condition or level of functioning.

- Conforms with standards of good medical practice, uniformly recognized and professionally endorsed by the general medical community at the time it is provided.
- Not mainly for the convenience of the member, a physician or other provider.
- The most appropriate medical service, supply or level of care that can safely be provided. When applied to inpatient care, it further means that your medical symptoms or condition require that the services cannot be safely provided to you as an outpatient.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance based on reasonable and customary charge. Plan providers accept the Plan allowance as payment in full.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval or a referral and (2) where failure to obtain precertification, prior approval or a referral results in a reduction of benefits.

Us/We

Us and We refer to Health Alliance Medical Plans.

You

You refers to the enrollee and each covered family member.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care of treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-851-3379. You may also prove that your claim is an urgent care claims by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Coverage Information

- **No pre-existing condition limitation**

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

- **Where you can get information about enrolling in the FEHB Program**

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

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

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

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact 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 dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 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 of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contract your human resources office or retirement system from additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contract your human resources office or retirement system for additional information.
Married Children	Married children(but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

- **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 2012 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 2011 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.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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 26.

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. Other Federal Programs

Important information about 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 eligible 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 or $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents including adult children(through the end of the calendar year in which they turn 26) 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 tax dependents including adult children(through the end of the calendar year in which they turn 26), which are not covered or reimbursed, by FEHBP or FEDVIP coverage or 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.
- **If you are a new or newly eligible employee**, you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

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

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employees 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 for enrollment.**

FEDVIP is available to eligible Federal and Postal Service 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

All dental plans provide a comprehensive range of services, including:

- 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 for dependent children up to age 19.

Vision Insurance

All 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/vision and www.opm.gov/insure/dental. These sites also provide 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 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.	An individual is eligible to buy coverage in PCIP if: • He or she has a pre-existing medical condition or has been denied coverage because of the health condition; • He or she has been without health coverage for at least the last six months. (if the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP); • he or she is a citizen or national of the United States of resides in the U.S. legally. The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

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

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Summary of benefits for the High Option of the Health Alliance HMO Plan - 2012

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

Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copayment: $20 primary care; $30 specialist	19
Services provided by a hospital:		
• Inpatient	$200 copayment per day, up to a maximum $1000 per admission	36
• Outpatient	$250 per outpatient surgical admission	37
Emergency benefits:		
• In-area	$20 primary care physician office/$30 speciality physician office/$200 hospital ER	40
• Out-of-area	$20 primary care physician office/$30 specialty physician office/$200 hospital ER	40
Mental health and substance abuse treatment:	Regular cost-sharing	41
Prescription drugs:		
• Retail pharmacy	$15/$30/$50	44
• Mail order	$41.25/$82.50/$137.50	44
Dental care:	No benefit	48
Vision care:	$20 copayment for primary care physician office visit $30 copayment for specialist office visit	24
Special features:	• Flexible benefits option • Services for deaf and hearing impaired • Reciprocity benefits	49
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $1,500/Self Only or $3,000/ Family enrollment per year Some costs do not count toward this protection The out-of-pocket maximum for Specialty Prescription Drugs is $1,500 per member or $3,000 per family	15

2012 Rate Information

For 2012 health premium information, please see http://www.opm.gov/insure/health/tribes/rates/ or contact your tribe's Human Resources department.