FEHB Program Carrier Letter
All Fee-for-Service Carriers

U.S. Office of Personnel Management
Insurance Services Program

Letter No. 2008-07(c) **Date: April 11, 2008**

Fee-for-Service [5] Experience-rated HMO [n/a] Community-rated HMO [n/a]

Subject: 2009 Technical Guidance and Instructions for Preparing Proposals for Fee-For-Service Carriers

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2009 through December 31, 2009. Please refer to our annual *Call Letter* (Carrier letter 2008-06) dated March 11, 2008 for *policy guidance*. Benefit policies from prior years remain in effect.

Your complete proposal for benefit changes and clarifications is due no later than **May 31, 2008.** Please send a copy of your proposal to your contract specialist on a CD-ROM or other electronic means in addition to a hard copy. Your proposal should include the corresponding language that describes your proposed changes for the brochure. You do not need to send your fully revised 2009 brochure by May 31.

Your OPM contract specialist will negotiate with you 2009 benefits and finalize the negotiations in a closeout letter. Please send an electronic version of your fully revised 2009 brochure to your contract specialist within five business days following the receipt of the closeout letter **or** by the date set by your contract specialist.

As a reminder, each year we assess carriers' overall performance. We take into consideration your efforts in submitting benefit and rate proposals on time and your accurate and timely production and distribution of brochures, as major factors in your plan's overall performance. Enclosed for your convenience is a checklist (Attachment VIII) with the information you need to provide. Please return the completed checklist along with your benefit and rate proposals.

We look forward to working closely with you on these essential activities to ensure a successful Open Season again this year.

Sincerely,

Kay Ely
Associate Director
for Human Resources Products and Services

Enclosures

2009 FEHB Proposal Instructions

Preparing Your Benefit Proposal

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

- A plain language description of each proposed change (in worksheet format) and the revised language for your 2009 brochure;

- A plain language description of each proposed clarification (in worksheet format) and the revised language for your 2009 brochure; and

- A signed contracting official's form.

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

Value-Based Benefit Design

As stated in our *Call Letter*, we encourage proposals for value-based benefit designs. Please ensure you meet the following criteria in your proposals:

- Focus on prevention/screenings;
- Focus on patients with higher benefits utilization;
- Must have a population based management program in place (e.g. chronic care management);
- Must include a detailed management plan with a description of the methodology, procedures and timeline to implement the patient management program; and
- Must provide an estimate of the expected return on investment.

Medicare Enrollee Pilot

As stated in our *Call Letter*, we encourage proposals for pilot programs for FEHB enrollees who also have Medicare. Please ensure you meet the following criteria:

- Pharmacy Benefits Management Companies (PBM) must have a Medicare Part D contract;
- The program must be simple to administer;
- The program should be transparent to enrollees;
- The overall cost of the program must be beneficial to the government and to enrollees;
- The program must be voluntary for enrollees; and,
- The design of the pilot program must include sufficient metrics for evaluation.

Hearing Aids

We strongly encourage you to enhance hearing benefits for adults. In particular, we request all carriers add benefits for hearing aids for adults, including screening and testing services. Licensed and qualified hearing health care providers (hearing aid specialists, audiologists and otolaryngologists) should be included in provider networks for hearing aids and related services. As stated in the *Call Letter*, we are not requiring an offset to the incremental cost increase for this benefit.

Durable Medical Equipment (DME)
Please ensure your proposals for 2009 include a review of your DME benefits, and a statement concerning your coverage for assistive technologies.

Health Care Cost and Quality Transparency Initiatives
We continue to encourage you to expand your health care cost and quality transparency initiatives. We remind national plans that their price transparency data must be adjusted for regional differences in healthcare costs.

Organ/Tissue Transplants
We are updating the guidance on organ/tissue transplants which we provided in last year's technical guidance.

When a carrier determines that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at the time that determination is made. Carriers are not obligated to wait for the next contract year before they begin providing such benefits. We have also updated the following tables in Attachment II:

- Table 1– OPM's **required** list of covered organ/tissue transplants
- Table 2 – Recommended organ/tissue transplants when received as part of a clinical trial
- Table 3 – Recommended organ/tissue transplants

Prescription Drugs
All plans must meet creditable coverage requirements. The prescription drug benefit must be at least as good as the standard Medicare Part D Benefit.

As indicated in the 2007 Technical Guidance and Instructions for Preparing Benefits and Service Area Proposals for FFS Carriers prescription drug benefits for Fee-For-Service (FFS) plans listed in the *2009 Guide to Federal Benefits* will be consistent with the prescription drug payment levels listed for Health Maintenance Organizations (HMO). Prescription drug payment levels will be listed as Level I, Level II, and Level III. These levels will show your current copays/coinsurance for generic, brand name and non-formulary, as well as other specific drug categories that may apply to your plan. If your plan has multiple (more than three payment levels, i.e., generic, brand name and non-formulary) for prescription drug coverage, please work with your OPM contract specialist to ensure that we accurately reflect your coverage in the *2009 Guide to Federal Benefits.*

Plans must clearly show their prescription drug benefits in terms of copays /coinsurance and payment levels in the 2009 brochure. For example, Level I is a $10 copayment for generic drugs (others may apply); Level II is a $30 copayment for brand drugs (others may apply); and Level III is 50% of the plan allowance ($35 minimum) for non-formulary brand drugs (others may apply).

Benefit Changes
Your proposal must include a narrative description of each proposed benefit change. You must show all changes, however slight, that result in an increase or decrease in benefits as benefit changes, even if there is no rate change. Also, please answer the following questions in worksheet format for **each** proposed benefit change. Indicate if a particular question does not apply and use a separate page for

each change you propose. We will return any incorrectly formatted submissions. ***We require the following format:***

- Describe the benefit change completely. Show the proposed brochure language, including the "How we change for 2009" section in "plain language" that is, in the active voice and from the enrollee's perspective. Show clearly how the change will affect members. Be sure to show the complete range of the change. For instance, if you are proposing to add an inpatient hospital copay, indicate whether this change will also apply to inpatient hospitalizations under the emergency benefit**. If there are two or more changes to the same benefit, please show each change clearly.**

- Describe the rationale or reasoning for the proposed benefit change.

- State the actuarial value of the change, and whether the change represents an increase or decrease in (a) the existing benefit, and (b) your overall benefit package. If an increase, describe whether any other benefit offsets your proposal. Include the cost impact of this change as a biweekly amount for the Self Only and Self and Family rate. If there is no cost impact or if the proposal involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, as appropriate.

Benefit Clarifications

Clarifications are not benefit changes. Clarifications help enrollees understand how a benefit is covered**.** For each clarification:

- Show the current and proposed language for the benefit you propose to clarify; reference all portions of the brochure affected by the clarification. **Prepare a separate worksheet for each proposed clarification.** When you have more than one clarification to the same benefit you may combine them, but you must present the worksheet clearly. Remember to use plain language.

- Explain the reason for the benefit clarification.

Preparing Your Proposal for High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA)

High Deductible Health Plans (HDHP)

The Tax Relief and Health Care Act of 2006 signed by President George W. Bush in December 2006 requires the U.S. Department of the Treasury (Treasury) to release its annual cost-of-living adjustment (COLA) numbers no later than June 1. The COLA numbers are used to determine annual HSA contribution limits, HDHP deductible levels and out-of-pocket maximums.

Final numbers have not been released as of the issuance of this Technical Guidance; we anticipate small increases to the maximum contribution amount and the annual out-of-pocket maximum. For 2008, Treasury requires that an HDHP have an annual deductible of at least $1,100 for Self Only coverage and annual out-of-pocket expenses (deductibles, co-payments, etc.) that do not exceed $5,600. For Self and Family coverage, an HDHP must have an annual deductible of at least $2,200 and annual out-of-pocket expenses that do not exceed $11,200**. Both the deductible minimum and out-of-pocket expense**

maximums are indexed for inflation. We will not accept proposals with deductibles less than $1,100 for Self Only and $2,200 for Self and Family coverage.

An HDHP may not provide benefits for any year until the member meets the annual deductible. However, a plan may offer first-dollar coverage for preventive care (or have only a small deductible) and still be defined as an HDHP. Additional Treasury guidance may be found at: http:/www.treas.gov/offices/public-affairs/hsa/. The following guidance applies for health plans proposing to offer an HDHP for 2009. We have provided a checklist of this guidance in Attachments III - VII. Please include this information in your proposal.

- HDHPs must continue to maintain full compliance with the Internal Revenue Code and all applicable Treasury rulings. These requirements are included in Attachment IV.
- HDHPs must be open to everyone within the defined service area eligible to enroll in the FEHB Program.
- HDHPs must offer an HSA or an HRA for enrollees who are not eligible to make contributions to an HSA. Attachment V includes a list of components.
- We will evaluate HDHP proposals in accordance with OPM premium rating guidelines.
- Premium pass-through amounts should not exceed 50% of the plan's deductible.
- Premium pass-through amounts should not exceed 25% of the net-to-carrier premium.
- FEHB plans, including HDHPs, must meet creditable coverage requirements for prescription drug coverage.
- Proposals should reflect costs only, including the amounts the plan will deposit/credit to the enrollee's HSA or HRA. Attachment V includes a list of costs.
- Proposals should clearly describe the health benefits that the plan offers, including deductibles, coppayments, and any other out-of-pocket amounts for in-network and out-of-network services, if applicable.
- Proposals should include a description of catastrophic limitations and how they apply to Self Only and Self and Family enrollments (i.e., is there any "imbedded" one-person catastrophic limit).
- You should describe your HDHP provider network and provide evidence that there will be sufficient access to in-network primary, specialty and tertiary providers.
- Proposals should include a description of the HDHP health education program components that the plan offers.
- Proposals should also include sophisticated health education and consumer education components that leverage state-of-the-art information technology and provide for transparency in cost and quality.
- Proposals should include a complete description of the geographic service area.
- Proposals should include a certification that the state in which your health plan operates has no mandates requiring first dollar coverage for any medical benefit that would keep the plan from qualifying as an HDHP.

Health Savings Accounts (HSA) and Health Reimbursement Arrangements (HRA)

Tax-favored HSAs are available to those who have an HDHP. However, HSAs are not open to people enrolled in Medicare or another medical benefit health plan (with certain exceptions as provided in Treasury's guidance). Therefore, health plans that are proposing HDHP/HSAs should also propose an HRA of equivalent value for enrollees who are ineligible for an HSA. The HRA could be used for medical expenses, including Medicare premiums. The following guidance applies for health plans proposing to offer an HDHP and HSA/HRA for 2009:

- HSAs must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and applicable Treasury guidance.
- The pass-through contribution to an HRA must be of equivalent value to the HSA offered under the plan.
- Deductible amounts should not exceed the IRS maximum HSA contribution limit for the year in question (conservative estimates should be used with respect to the IRS indexed amounts if they have not been published when benefit proposals are submitted).
- If an enrollee with an HRA becomes eligible to make HSA contributions, any balance remaining in the HRA may be transferred to the HDHP's HSA, subject to IRS rules and limitations. This transfer may only take place at the end of the plan year. The HSA will be effective the following plan year.
- FEHBP carriers that offer HDHPs and HSAs/HRAs must provide assurances that their trustees are financially stable. Health plan proposals should clearly state how they intend to meet Treasury requirements pertaining to HSA and HRA fiduciary responsibilities. At a minimum, the trustee/custodian must be rated by a major financial rating service in one of its two highest categories for the most recent available rating period. All proposals should provide evidence of this minimum rating level. If the carrier manages the HSA and HRA accounts itself, it must provide assurance that it meets IRS fiduciary requirements.
- Plans that offer HDHP and HSA/HRA proposals must describe, in detail, the flow of funds from receipt to disbursement to the designated fiduciary.
- Plans must also provide a detailed description from the fiduciary demonstrating how the HSAs and HRAs financial mechanisms and transactions will be established and monitored, including earnings for individual accounts.
- HDHP and HSA/HRA proposals that include the use of debit or credit cards should describe in detail how the plan will manage and monitor them, including accounting for earned interest. Transaction fees associated with debit cards may not be charged to FEHB Program funds.
- Proposals should state how fees and ancillary charges to individual accounts will be paid for.
- HRAs must meet applicable Treasury requirements.

Preparing Your 2009 Brochure

We will continue to use the brochure process we implemented last year. This process is a web application that uses database software. The web application will generate a 508 compliant PDF.

The *2009 FEHB Program Application User Manual* will be available May 1st. In June, we will provide in-house training for all plans that did not use the tool exclusively for both printing purposes as well as for use on the FEHB website. There will be ten separate training sessions held at OPM. We will send an email via the FEHB Carriers listserv as to the dates and times of these trainings. Please send any comments or questions pertaining to the Brochure Creation Tool to Angelo Cueto at angelo.cueto@opm.gov.

Plans are responsible for entering all data into Section 5 Benefits and updating all plan specific information in the brochure tool by September 15, 2008. Plans will be unable to make any changes on September 16, 2008 as we will lock down the tool to enable contract specialists to review PDF versions of plan brochures. If changes need to be made, we will unlock plan brochures on a case-by-case basis.

The *2009 FEHB Brochure Handbook* will be ready by June 1st. Plans can download the *Handbook* from the file manager at http://www.opm.gov/filemanager. To receive a user name and password, please contact Angelo Cueto at (202) 606-1184 or angelo.cueto@opm.gov. If you are proposing a new option, please send Section 5 Benefits information along with your proposal. In August, we will also send you a brochure quantity form and other related Open Season instructions.

By August 11, 2009, we will issue a second version of the *2009 FEHB Brochure Handbook* with final language changes and shipping labels. We will send each plan a brochure quantity form when the OPM contract specialist approves the brochure for printing.

Attachment I: Carrier Contracting Officials

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

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

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

for _____(Plan).

Enrollment code (s):_____

Typed name Title Signature Date

_____

_____

_____

_____

_____

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

_____
(Typed name and title)

_____ _____
(Phone number) (FAX number)

_____
(Email address)

Attachment II 2009 Organ/Tissue Transplants and Diagnoses:

Table 1: Required Coverage

I. Solid Organ Transplants: Subject to Medical Necessity	Reference
Cornea	Call Letter 92-09
Heart	Call Letter 92-09
Heart-lung	Call Letter 92-09
Kidney	Call Letter 92-09
Liver	Call Letter 92-09
Pancreas	Call Letter 92-09
Intestinal transplants (small intestine with the liver) or small intestine with multiple organs such as the liver, stomach, and pancreas	Carrier Letter 2001-18
Lung: Single/bilateral/lobar	Carrier Letter 91-08
II. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. Plan's Denial is Limited to the Staging of the Diagnosis (e.g. acute, chronic).	
Allogeneic transplants for:	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	
Advanced Hodgkin's lymphoma	
Advanced non-Hodgkin's lymphoma	
Chronic myelogenous leukemia	
Hemoglobinopathy (i.e., Fanconi's, Thalessemia major)	
Myelodysplasia/Myelodysplastic syndromes	
Severe combined immunodeficiency	
Severe or very severe aplastic anemia	
Amyloidosis	
Autologous transplants for:	
Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Call Letter 96-08B
Advanced Hodgkin's lymphoma	Call Letter 96-08B
Neuroblastoma	Call Letter 96-08B
Advanced non-Hodgkin's lymphoma	Call Letter 96-08B
Amyloidosis	
Autologous tandem transplants for:	
Recurrent germ cell tumors (including testicular cancer)	Call Letter 2002-14
Multiple myeloma	
De-novo myeloma	

III. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity	
Allogeneic transplants for:	
Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)	
Autologous transplants for:	
Multiple myeloma	Carrier Letter 94-23, Call Letter 96-08B
Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Carrier Letter 94-23, Call Letter 96-08B
IV. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials.	
Autologous transplants for:	
Breast cancer	Carrier Letter 94-23 Call Letter 96-08B
Epithelial ovarian cancer	Carrier Letter 94-23 Call Letter 96-08B
V. Mini-transplants (non-myeloablative, reduced intensity conditioning): Subject to Medical Necessity	
VI. Tandem transplants: Subject to medical necessity	

Table 2: Recommended For Coverage. Transplants Under Clinical Trials

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/investigational to being consistent with standards of good medical practice in the U.S. for the diagnosed condition.

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2009?	
	Yes	**No**
Allogeneic transplants for:		
Chronic lymphocytic leukemia		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Myelodysplasia/Myelodysplastic syndromes		
Multiple myeloma		
Multiple sclerosis		
Nonmyeloablative allogeneic transplants for:		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Myelodysplasia/Myelodysplastic syndromes		
Advanced Hodgkin's lymphoma		
Advanced non-Hodgkin's lymphoma		
Breast cancer		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Colon cancer		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Myeloproliferative disorders		
Non-small cell lung cancer		
Ovarian cancer		
Prostate cancer		
Renal cell carcinoma		
Sarcomas		
Autologous transplants for:		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		

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

Table 3: Recommended For Coverage

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/investigational to being consistent with standards of good medical practice in the U.S. for the diagnosed condition.

	Does your plan cover this transplant for 2009?	
Solid Organ Transplants	**Yes?**	**No?**
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		
Myeloproliferative disorders		
Sickle cell anemia		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom's macroglobulinemia		

Attachment III: HDHP Checklist

High Deductible Health Plan Proposal Information	
1. HDHPs must continue to maintain full compliance with the Internal Revenue Code and all applicable Treasury rulings. These requirements are included in Attachment IV.	
2. HDHPs must be open to everyone within the defined service area eligible to enroll in the FEHB Program.	
3. HDHPs must offer a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for enrollees who are not eligible to make contributions to an HSA. Attachment V includes a list of components	
4. We will evaluate HDHP proposals in accordance with OPM premium rating guidelines. • Premium pass-through amounts should not exceed 50% of the plan's deductible. • Premium pass-through amounts should not exceed 25% of the net-to-carrier premium.	
5. FEHBP plans, including HDHPs, must meet creditable coverage requirements for prescription drug coverage.	
6. Proposals should reflect costs only, including the amounts the plan will deposit/credit to the enrollee's HSA or HRA. Attachment V includes a list of costs.	
7. Proposals should clearly describe the health benefits that the plan offers, including deductibles, co-payments, and any other out-of-pocket amounts for in-network and out-of-network services, if applicable	
8. Complete Attachment VI.	
9. Proposals should include a description of catastrophic limitations and how they apply to Self Only and Family enrollments (i.e., is there any "imbedded" one-person catastrophic limit).	

Attachment III: HDHP Checklist (Cont.)

High Deductible Health Plan Proposal Information	
10. You should describe your HDHP provider network and provide evidence that there will be sufficient access to in-network primary, specialty and tertiary providers.	
11. Proposals should include a description of the HDHP health education program components that the plan offers.	
12. Proposals should also include a description of the consumer education the plan intends to provide including appropriate use of HSA/HRA funds for necessary expenses.	
13. Proposals should include a complete description of the geographic service area.	
14. Proposals should include a certification that the state in which your health plan operates has no mandates requiring first dollar coverage for any medical benefit that would keep the plan from qualifying as an HDHP.	
15. HSAs must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and applicable Treasury guidance.	
16. The pass-through contribution to an HRA must be of equivalent value to the HSA offered under the plan.	
17. Deductible amounts should not exceed the IRS maximum HSA contribution limit for the year in question. (conservative estimates should be used with respect to the IRS indexed amounts if they have not been published when benefit proposals are submitted).	
18. If an enrollee with an HRA becomes eligible to make HSA contributions, any balance remaining in the HRA may be transferred to the HDHP's HSA, subject to IRS rules and limitations. This transfer may only take place at the end of the plan year. The HSA will be effective the following plan year.	

Attachment III: HDHP Checklist (Cont.)

HSA and HRA Proposal Information	
19. FEHBP carriers that offer HDHPs and HSAs/HRAs must provide assurances that their trustees are financially stable. Health plan proposals should clearly state how they intend to meet Treasury requirements pertaining to HSA and HRA fiduciary responsibilities. At a minimum, the trustee/custodian must be rated by a major financial rating service in one of its two highest categories for the most recent available rating period. All proposals should provide evidence of this minimum rating level. If the carrier manages the HSA and HRA accounts itself, it must provide assurance that it meets IRS fiduciary requirements.	
20. Plans that offer HDHP and HSA/HRA proposals must describe in detail, the flow of funds from receipt to disbursement to the designated fiduciary.	
21. Plans must also provide a detailed description from the fiduciary demonstrating how the HSAs and HRAs financial mechanisms and transactions will be established and monitored, including earnings for individual accounts.	
22. HDHP and HSA/HRA proposals that include the use of debit or credit cards should describe in detail how the HSA/HRA would be managed and monitored, including accounting for earned interest.	
23. Proposals should state how fees and ancillary charges to individual accounts will be paid for.	
24. HRAs must meet applicable Treasury requirements.	

Attachment IV: Medicare Prescription Drug, Improvement and Modernization Act of 2003

HDHPs must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

Requirement	Does Your FEHB HDHP Meet These Requirements? Yes/No.
The minimum annual deductible is not less than $1,100 for Self Only coverage and $2,200 for Self and Family coverage. These deductibles are indexed each year and may change for 2009.	
The maximum amount of out-of-pocket limits does not exceed $5,600 for Self Only coverage and $11,200 for Self and Family coverage. These out-of-pocket limits are indexed each year and may change for 2009.	
An individual is not eligible for an FEHB HDHP if he/she has another health plan which is not an FEHB HDHP and which offers the same coverage as the HDHP. Exception: Certain plans are excluded from being considered as a health plan if they offer coverage for any benefit provided by permitted insurance, and coverage for accidents, disability, dental care, vision care, or long-term care.	
A deductible for preventive care does not exclude a plan from being an HDHP.	
For network plans, an HDHP may have an out-of-pocket limit for services provided outside of a network which exceeds the annual out-of-pocket maximum.	
Services provided outside of a network may not apply toward your annual HDHP deductible.	

Attachment V: Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA) Components

HDHP proposals must include both HSA and HRA components. The HRA component is available only to enrollees who are ineligible for an HSA.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator		
Fees		
Eligibility		
Funding		
• Self Only coverage		
• Self and Family coverage		
Contributions/credits		
• Self Only coverage		
• Self and Family coverage		
Access funds		
Distributions/withdrawals		
• Medical		
• Non-medical		
Availability of funds		
Account owner		
Portable		
Annual rollover		

Attachment VI: Costs

Proposals should reflect costs only, including the amounts to be deposited/credited to the enrollee's HSA or HRA.

ITEM	HSA	HRA
Premium Pass Through Amount Premium Pass through should not exceed 50% of plan's deductible and 25% of net-to-carrier premium.		
Account set-up fee		
• Option 1: Electronic enrollment		
• Option 2: Manual enrollment		
Account maintenance fee		
• Option 1: Paid by account holder		
• Option 2: Paid by employer		
Account Miscellaneous Fees		
• Monthly service charge		
• Paper statement		
• Excess contribution adjustment		
• Debit card for new accounts		
• Debit card reorder		
• Debit card additional card order		
• Tax statement copy		
• Check transactions		
• Debit card transactions		

Attachment VII: SUMMARY OF HIGH DEDUCTIBLE HEALTH PLAN FOR FEDERAL MEMBERS

Lifetime Maximum	Not Applicable	
	Plan Providers	**Non-Plan Providers**
Annual Deductible (Except Preventive Services if applicable)	Self: $XX Self and Family: $XX	Self: $XX Self and Family: $XX
Maximum Annual Copayment (stop-loss)	Self: $XX Self and Family: $XX	Self: $XX Self and Family: $XX

	Member Pays	
	Plan Provider	**Non-Plan Provider**
1ST DOLLAR BENEFITS (not subject to the annual deductible)		* Plus any difference between our payment and the actual charges
PREVENTIVE AND SCREENING SERVICES		
Immunizations		
Well Child Immunizations		
TB Skin Test		
Bone Density Screening		
Pap Test		
Well Woman Exam		
Glucose Screening		
Chlamydia Infection Screening		
Colorectal Screening (FOBT, colonoscopy and Sigmoidoscopy)		
Mammography – Screening		
Well Child Care Physician Office Visits (through age _)		
Well Child Care Laboratory Tests		
HEALTH ASSESSMENT AND DISEASE MANAGEMENT SERVICES		
COVERED SERVICES		
PHYSICIAN SERVICES		
Physician Office Visits		
Physician Home Visits		
Physician Hospital Visits		
Physician Skilled Nursing Facility Visits		
ER Visits (Physician Charge)		
Urgent care	• Primary Care Physician: • Specialist:	
Consultation Visits (inpatient)		
BEHAVIORAL HEALTH PHYSICIAN SERVICES		
Mental Health Physician Visits		
Substance Abuse Physician Visits		
DIAGNOSTIC TESTS, LABORATORY AND RADIOLOGY		
Diagnostic Tests (Pre-surgical, X-rays)		
Evaluation for Hearing Aids		
Allergy Testing and Treatment Materials		
Laboratory and Pathology		
Radiology		

	Member Pays	
	Plan Provider	**Non-Plan Provider**
MATERNITY AND NEWBORN CARE		
Maternity Care		
Newborn Care		
Circumcision		
SURGICAL SERVICES		
Anesthesia		
Assistant Surgeon		
Surgery		
Treatment of Morbid Obesity		
ORGAN TRANSPLANT SERVICES (Transplants must receive prior authorization unless otherwise noted)		
Corneal Transplants (no pre-auth)		
Kidney Transplants (no pre-auth)		
Simultaneous Small Bowel/Multivisceral Transplant		
Small Bowel Transplant		
Organ Donor Services		
Transplant Evaluation		
	Contracted Provider	**Non-Contracted Provider**
Bone Marrow Transplants		
Heart and Lung Transplants		
Heart Transplants		
Liver Transplant		
Lung Transplants		
Simultaneous Kidney/Pancreas Transplant		
EMERGENCY FACILITY SERVICES		
Ambulance (Ground)		
Ambulance (Air)		
Emergency Service		
FACILITY SERVICES		
Ambulatory Surgical Center		
Birthing Center		
Hospital • Based on semi-private room rate • Intermediate care, ICU, CCU		
Observation Care		
Skilled Nursing Facility (___days per year)		
CANCER TREATMENT		
Chemotherapy		
Radiation Therapy		
HOME SERVICES		
Home Health Care		
Hospice		
APPLIANCES, EQUIPMENT AND SUPPLIES		
Durable Medical Equipment, Orthotics and Prosthetics		
Hearing Aids		
REHABILITATIVE SERVICES		
Physical Therapy and Occupational Therapy		
Speech Therapy		
OTHER MEDICAL SERVICES		
Blood and Blood Products		
Dialysis and Supplies		

	Member Pays	
	Plan Provider	**Non-Plan Provider**
Inhalation Therapy		
Medical Foods		
PRESCRIPTION DRUGS		
Home IV Therapy		
Human Growth Hormone Therapy		
Injectable Drugs (physician administered)		
Prescription Drugs	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Level I Level II Level III	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Not a benefit
Insulin	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Level I Level II Level III	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Not a benefit
Diabetic Supplies	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Level I Level II Level III	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Not a benefit
Spacers	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)**	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Not a Benefit
Oral Contraceptives	**Retail Pharmacy: (30 day supply)** Regular Plan benefits **Mail Order: (90 day supply)** Regular Mail Order Benefits	**Retail Pharmacy: (30 day supply)** Regular Plan benefits **Mail Order: (90 day supply)** Not a Benefit
Contraceptive Diaphragms	**Retail Pharmacy and Mail Order**	**Retail Pharmacy**
Treatment of Erectile Dysfunction due to organic cause		
FAMILY PLANNING, FERTILITY AND INFERTILITY SERVICES		
Contraceptive Implants		
Contraceptive IUD		

	Member Pays	
	Plan Provider	**Non-Plan Provider**
Diagnosis of Infertility		
In Vitro Fertilization		
Artificial Insemination		
Tubal ligation		
Vasectomy		

Attachment VIII: Checklist

Federal Employees Health Benefits Program Annual Call Letter --- Checklist

Topic	Included in Proposal
1. Quality and Value in Benefit Design – Including a description of current consumer outreach activities and how you propose to enhance them.	
2. Medicare Enrollee Pilot Proposal	
3. Hearing Benefits - Proposed coverage of hearing benefits for adults	
4. Durable Medicare Equipment	
5. Health Information Technology (HIT) and Transparency	
6. Organ/Tissue Transplants	
7. High Deductible Health Plan Proposal and All Attachments	

Please return this checklist with your CY 2009 benefit and rate proposal