FEHB Program Carrier Letter
All Fee-for-Service Carriers

U.S. Office of Personnel Management
Insurance Services Program

Letter No. 2007-13(c) **Date**: April 12, 2007

Fee-for-Service [9] Experience-rated HMO [n/a] Community-rated HMO [n/a]

Subject: 2008 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, 2008 through December 31, 2008. Please refer to our annual *Call Letter* (Carrier letter 2007-07) dated March 7, 2007 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, 2007.** Please send a copy of your proposal on a CD-Rom or other electronic means to your contract specialist 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 2008 brochure by May 31.

Your OPM contract specialist will negotiate your 2008 benefits with you and finalize the negotiations in a closeout letter. Please send an electronic version of your fully revised 2008 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 VII) 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,

Robert F. Danbeck
Associate Director
for Human Resources Products and Services

Enclosures

2008 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 2008 brochure;
- A plain language description of each proposed clarification (in worksheet format) and the revised language for your 2008 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.

Hearing Benefits for Newborns and Children

As stated in our "Call Letter", we encourage proposals for hearing benefits for newborns and children that include screenings, testing, diagnostic evaluations, and treatment by licensed hearing professionals, including audiologists for both professional services as well as hearing aids.

Preventive Care.

As stated in our "Call Letter", we encourage you to review your current preventive benefits for adults, compare them to the United States Preventive Services Task Force (USPSTF) recommendations, and propose benefit changes to address any gaps between the two. The USPSTF guidelines are at http://www.ahrq.gov/clinic/uspstfix.htm.

Organ/Tissue Transplants

Please refer to our guidance in the 2007 Technical Guidance and Instructions for Preparing Benefits and Service Area Proposals for FFS carriers at http://www.opm.gov/carrier/carrier_letters/2006/2006-13Cattachment.pdf

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 *2008 Guide to Federal Employees Health Benefits Plans* 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 *2008 Guide to Federal Employees Health Benefits Plans.*

Plans must clearly show their prescription drug benefits in terms of copays /coinsurance and payment levels in the 2008 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 2008" 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-pocked maximum. For 2007, 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 $5,500. 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 $11,000. **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 2008. We have provided a checklist of this guidance in Attachments II - VII. Please include this information in your proposal.

We have revised the HDHP proposal requirements according to the Tax Relief and Health Care Act of 2006.

- HDHPs must continue to maintain full compliance with the Internal Revenue Code and all applicable Treasury rulings. These requirements are included in Attachment III.
- HDHPs must be open to everyone within the defined service area eligible to enroll in the FEHB Program.
- 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 IV 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.
- FEHBP 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, co-payments, 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 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 2008:

- 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 2008 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 automatically generate a 508 compliant PDF.

The *2008 FEHB Program Application User Manual* will be available April 1st. Each plan will be required to show proficiency in using the brochure application tool by April 16th by entering data from a sample brochure into the tool. In May, we will provide in-house training for all plans who did not meet our proficiency requirements. There will be four separate training sessions held at OPM from 9am to 2pm on the following dates: May 2nd, 15th, 22nd, and 29th. Each plan must also send its 2008 508 compliant brochure from the tool to the printer for testing. Please provide us with comments indicating any issues the printer experienced by May 16, 2007.

The *2008 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 10, 2007, we will issue a second version of the *2008 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.

Plans are responsible for entering all data into Section 5 Benefits and updating all plan specific information in the brochure tool by September 15, 2007. Plans will be unable to make any changes on September 16, 2007 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.

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: 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 III.	
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 IV 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.	

Attachment II: HDHP Checklist (Cont.)

High Deductible Health Plan Proposal Information	
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).	
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 health 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.	

Attachment II: HDHP Checklist (Cont.)

HSA and HRA Proposal Information	
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.	
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 these 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 III: 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	Plan's Federal HDHP
''(A) IN GENERAL.—The term 'high deductible health plan' means a health plan—	
''(i) which has an annual deductible which is not less than— ''(I) $1,100 for self only coverage, and	
''(II) twice the dollar amount in subclause (I) for family coverage, and	
''(ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—	
''(I) $5,500 for self-only coverage, and	
''(II) twice the dollar amount in subclause (I) for family coverage.	
''(B) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B). ''(1) ELIGIBLE INDIVIDUAL.— ''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if— ''(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and ''(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan— ''(I) which is not a high deductible health plan, and ''(II) which provides coverage for any benefit which is covered under the high deductible health plan. **''(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—** **''(i) coverage for any benefit provided by permitted insurance, and** **''(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.**	
''(C) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary).	

Attachment III: Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Cont.)

Requirement	Plan's Federal HDHP
''(D) SPECIAL RULES FOR NETWORK PLANS.—In the case of a plan using a network of providers—	
''(i) ANNUAL OUT-OF-POCKET LIMITATION.—Such plan shall not fail to be treated as a high deductible health plan by reason of having an out-of-pocket limitation for services provided outside of such network which exceeds the applicable limitation under subparagraph (A)(ii).	
''(ii) ANNUAL DEDUCTIBLE.—Such plan's annual deductible for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2).	

Attachment IV: 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 V: 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 VI: 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 (stoploss)	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)		

	Member Pays	
	Plan Provider	**Non-Plan Provider**
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		
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		

	Member Pays	
	Plan Provider	**Non-Plan Provider**
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		
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

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

Attachment VII: Checklist

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

- Your proposal should describe your commitment to the four "cornerstones" for Federal health care programs to implement health information technology (HIT) as described in the 2007 Call Letter along with specific examples of how you are implementing these cornerstones for your health plan population.

- In addition you are required to submit a report by August 31, 2007, on the specific actions you have taken on the following steps:
  1. Actions to make consumers aware of the value of HIT;
  2. Actions to make personal health records available to enrollees based on their medical claims, lab test results and medication history;
  3. Actions to meet our healthcare cost and transparency standards;
  4. Actions to provide incentives for ePrescribing; and,
  5. Actions to ensure compliance with Federal requirements that protect the privacy of individually identifiable health information.

Topic	***Included in Proposal***
▪ Health Care Costs and Quality Transparency Initiatives	_____
▪ Health Information Technology Initiatives	_____
▪ Four Cornerstones	_____
▪ Preventive Care Initiatives	_____
▪ Proposed Coverage of Hearing Benefits For Newborns and Children	_____
▪ High Deductible Health Plan Proposal and All Attachments	_____

Please return this checklist with your CY 2008 benefit and rate proposal