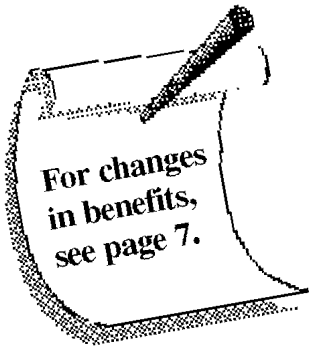
HealthPlus of Michigan

http://www.healthplus.com

2001

A Health Maintenance Organization



Serving: Greater Flint and Saginaw areas

Enrollment in this Plan is limited; see page 6 for requirements.

This Plan has Excellent accreditation from the NCQA. See the 2001 Guide for more information on NCQA.

Enrollment codes for this Plan:

X51 Self Only
X52 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

Federal Employees Health Benefits Program

RI 73-648

Table of Contents

Introduction

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

This brochure describes the benefits of HealthPlus of Michigan under our contract (CS 2712) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means HealthPlus of Michigan, Inc.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

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.

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 only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

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

Who provides my healthcare

Each family member that is covered by HealthPlus must choose a Primary Care Physician from the Provider Directory (parents are expected to select for their children). This list includes more than 1,000 doctors who specialize in Family Practice, Internal Medicine, or Pediatrics. The listing for each Primary Care Physician also shows a "primary hospital." This is the hospital where your Primary Care Physician will direct you for hospital services in most instances. When you select a Primary Care Physician, you also are agreeing to use the hospital listed.

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

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

Patient's Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- HealthPlus service area
- HealthPlus Subscriber Contract
  - Covered benefits, including prescription drug coverage
  - Description of emergency health coverages and benefits
  - Out-of-area coverage and benefits
  - An explanation for copayments and any other out-of-pocket expense
- Continuity of treatment
  - Arrange for the continuation of treatment by that provider; or
  - Assist the member in selecting a new provider
- Additional information
  - Provider information
  - Physician credentials
  - Physician status/discipline
  - Specific benefits
  - Financial arrangement with physicians
  - Who to contact

If you want more information about us, call (800) 332-9161, or write to our Customer Service Department at: 2050 South Linden Road, P.O. Box 1700, Flint Michigan 48501-1700 . You may also contact us by fax at (810) 230-2093 or visit our website at www.healthplus.com.

Service Area

To enroll with us, you must live in our service area. This is where our providers practice.

Our service area is:All of Arenac (except Moffat and Clayton Township), Bay, Genesee, Lapeer, Livingston, Saginaw, Shiawassee, and Tuscola Counties in Michigan.

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. Services will be covered if a non-affiliated provider renders them when an emergency prevents you from receiving services from a participating provider.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area, you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. Eligible college students are covered for emergency illnesses or injuries that occur when they are out of the service area. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling us at (800) 332-9161, or checking our website, www.healthplus.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 8.2% for Self Only or 0.4% for Self and Family.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 332-9161.

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do

Each family member that is covered by us must choose a Primary Care Physician from the Provider Directory (parents are expected to select for their children). This list includes doctors who specialize in Family Practice, Internal Medicine, or Pediatrics. The listing for each Primary Care Physician also shows a "primary hospital." This is the hospital where your Primary Care Physician will direct you for hospital services in most instances. When you select a Primary Care Physician you are also agreeing to use the hospital listed. The Primary Care Physician you choose will coordinate your overall medical care, including arranging for hospital admissions or care by a specialist when medically necessary. HealthPlus strives to keep the Provider Directory as up-to-date as possible. However, information may change after the Directory has been printed. If the Physician you select is no longer accepting patients, please select another.

You may want to call the physician you have chosen prior to calling our Customer Service Department at (800) 332-9161 with your selection. You must notify us before receiving covered services from the new Primary Care Physician.

- **Primary care**

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

If you want to change Primary Care Physician or if 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. You will receive either written notification from us, or a referral form from your Primary Care Physician, which will specify the number of visits and the length of time covered by this referral. If your referral expires and you need additional visits, contact your Primary Care Physician. Services of other providers are covered only when you have been referred by your Primary Care Physician with the following exception: a woman may see one of our Plan gynecologists for her annual routine examination without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your Primary Care Physician will work with specialist and us to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your Primary Care Physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your Primary Care Physician. Your Primary Care Physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your Primary Care Physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or 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 Plan; or

  - reduce our service area and you enroll in another FEHB Plan, you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

- Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at (800) 332-9161. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the hospital benefits of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

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

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

Section 4. Your costs for covered services

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

- **Copayments**

  A copayment is a fixed amount of money you pay to the provider when you receive services.

  Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay nothing per admission.

- **Deductible**

  A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. We have no deductible.

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

- **Coinsurance**

  Coinsurance is the percentage of our negotiated fee that you must pay for your care. We have no coinsurance.

Your out-of-pocket maximum

We have no out-of-pocket maximum. Your out-of-pocket expenses covered under this plan are limited to stated copayments that are required for a few benefits.

Section 5. Benefits — OVERVIEW

(See page 7 for how our benefits changed this year and page 55 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at (800) 332-9161 or at our website at www.healthplus.com.

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per visit.
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment by the Member's Primary Care Physician • Office medical consultations • Second surgical opinion	 Nothing Nothing Nothing Nothing if examination occurs during hospital stay; otherwise, $10 per visit $10 per visit $10 per visit
At home	$10 per visit

Lab, X-ray and other diagnostic tests	You Pay
Tests, such as: ● Blood tests ● Urinalysis ● Non-routine pap tests ● Pathology ● X-rays ● Non-routine Mammograms ● CAT Scans/MRI ● Ultrasound ● Electrocardiogram and EEG	Nothing

Preventive care, adult	You Pay
Routine screenings, such as: ● Blood lead level – One annually for children only; recommended at age 9-12 months. ● Total Blood Cholesterol – once every five years, ages 18 or older ● Colorectal Cancer Screening, including ●● Fecal occult blood test – one annually age 15 or older	$10 per visit
●● Sigmoidoscopy, screening – every 3-5 years starting at age 50	$10 per visit
Prostate Specific Antigen (PSA test) – one annually for men age 50 and older	$10 per visit
Routine pap test – every 1-3 years beginning at age 18 Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and Treatment*.	$10 per visit
Routine mammogram –covered for women age 35 and older, as follows: ● Baseline by the age of 40 ● From age 40 through 49, 1 mammogram every one or two years ● At age 50, one yearly	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel. *Examinations, reports, or any other services related to requirements or documentation of health status for employment, licenses, insurance, travel, or for educational or sports/recreational purposes;*	*All charges*

Preventive Care, Adult- Continued on next page

Preventive care, adult *(Continued)*	**You Pay**
Routine Immunizations, limited to: ● Tetanus-diphtheria (Td) booster – once every 10 years, ages18 and over (except as provided for under Childhood immunizations) ● Influenza - annually age 65 and older ● Pneumococcal recommended at age 65	Nothing
Preventive care, children	**You Pay**
● Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
● Examinations, such as: ●● Examinations done on the day of immunizations (through age 22) ● Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per visit
Maternity care	**You Pay**
Complete maternity (obstetrical) care, such as: ● Prenatal care ● Delivery ● Postnatal care Note: Here are some things to keep in mind: ● You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. ● You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. ● We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. ● We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 per visit
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*

Family planning	You Pay
● Voluntary sterilization ● Surgically implanted contraceptives ● Injectable contraceptive drugs ● Intrauterine devices (IUDs) ● Medically-indicated genetic testing and counseling per generally accepted medical practice	Nothing
Not covered: ● *Reversal of voluntary surgical sterilization and all associated cost* ● *Premarital exams or classes*	*All charges*

Infertility services	You Pay
Diagnosis and treatment of infertility, such as: ● Artificial insemination: ●● intravaginal insemination (IVI) ●● intracervical insemination (ICI) ●● intrauterine insemination (IUI) ● Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	Nothing
Not covered: ● *Assisted reproductive technology (ART) procedures, such as:* ●● *in vitro fertilization* ●● *embryo transfer and GIFT* ●● *embryo transfer and ZIFT* ● *Services and supplies related to excluded ART procedures* ● *Reversal of a voluntary sterilization and all associated costs* ● *Pre-embryo cyro preservation techniques and associated services* ● *Infertility services if one of the partners has previously undergone surgical sterilization or if one of the partners is menopausal or post menopausal* ● *All services related to a surrogate parenting arrangements of any kind* ● *Cost of donor sperm and all associated costs*	*All charges*

Allergy care	You Pay
Testing and treatment	$10 per visit
Allergy injection	Nothing
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You Pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 24. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We will only cover GHT when we preauthorize the treatment. The Primary Care Physician calls us for a referral. We will ask the Primary Care Physician to submit information that establishes that GHT is medically necessary. The submitted request is reviewed by HPM's Medical Director to determine medically necessity. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See services requiring our prior approval in Section 3.	$10 per visit

Not covered:
• *Assisted reproductive technology (ART) procedures, such as:*
  ●● *in vitro fertilization*
  ●● *embryo transfer and GIFT*
  ●● *embryo transfer and ZIFT*
• *Services and supplies related to excluded ART procedures*
• *Reversal of a voluntary sterilization and all associated costs*
• *Pre-embryo cyro preservation techniques and associated services*
• *Infertility services if one of the partners has previously undergone surgical sterilization or if one of the partners is menopausal or post menopausal*
• *All services related to a surrogate parenting arrangements of any kind*
• *Cost of donor sperm and all associated costs*
	All charges

Rehabilitative therapies	You Pay
Physical therapy, occupational therapy and speech ● Two consecutive months per condition are covered if significant improvement can be expected within the two months. Services are covered for each of the following: ●● qualified physical therapists; ●● speech therapists; and ●● occupational therapists. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. ● Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is covered with no limit on the number of visits.	Nothing
Not covered: ● *long-term rehabilitative therapy* ● *exercise programs* ● *vocational rehabilitation services*	*All charges*
Hearing services (testing, treatment, and supplies)	**You Pay**
Benefits for a Hearing Aid and hearing tests for fitting and post performance evaluation of a Hearing Aid	Nothing
Not covered: ● *Hearing aids ordered prior to the effective date of coverage under this Contract* ● *Replacement and/or repair because of loss or misuse;* ● *Batteries* ● *The additional cost of an eyeglass-type Hearing Aid or other Hearing Aid with special features that are not Medically Necessary over the conventional type of Hearing Aid*.	*All charges*
Vision services (testing, treatment, and supplies)	**You Pay**
● Initial pair of glasses after cataract surgery	$10 per visit
Not covered: ● *Eyeglasses or contact lenses and, examinations for them* ● *Eye exercises and orthoptics* ● *Radial keratotomy and other refractive surgery* ● *Eyeglasses for ocular injury*	*All charges*

Foot care	You Pay
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.	$10 per visit
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.*	*All charges*

Orthopedic and prosthetic devices	You Pay
Orthotic appliances and prosthetic devices (including breast prosthesis following a mastectomy) ● Artificial limbs and eyes; stump hose ● Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. ● Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. ● Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Nothing
Not covered: ● *Equipment that is not deemed Medically Necessary or is an upgrade to accepted standards.* ● *Orthotic Appliances when they are not used to support, align, prevent, correct or improve a defect of body form or function.* ● *Prosthetic devises when they do not replace a limb or other part of the body after accidental or surgical removal and/or when your body growth necessitates a replacement.*	*All charges*

Durable medical equipment (DME)	You Pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: ● Hospital beds; ● Wheelchairs; ● Crutches; ● Walkers; ● Blood glucose monitors; and ● Insulin pumps.	Nothing
Not covered: ● *Equipment that is not deemed Medically Necessary or is an upgrade to accepted standards.*	*All charges*
Home health services	**You Pay**
● Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed pratical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. ● Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: ● *Custodial, or domiciliary care, basic care, or housekeeping* ● *Personal comfort or convenience items such as television and telephone services* ● *Skilled Nursing Services provided on a twenty-four (24) hours basis in the home* ● *Private duty nursing services (except if Medically Necessary in an inpatient hospital setting).*	*All charges*
Alternative treatments	**You Pay**
Spinal Manipulation when provided by, or under the direction of, your Primary Care Physician, or provided by a Specialist Physician to whom you are appropriately Referred.	$10 per visit
Not covered: ● *Hypnosis* ● *Biofeedback* ● *Acupuncture*	*All charges*

Educational classes and programs	You Pay
• Medical Self-Care program utilizing the Healthwise Handbook • Tobacco Cessation Program based upon the Stages of Change behavioral model. • Health Resource Library stocked with over 200 books, videos, and audiocassettes for members to checkout. • Anonymous telephonic depression screening available 24 hours seven days a week. • Extensive community resource directory that identifies health promotion and disease prevention programs available in the communities we serve. Program discounts are negotiated whenever possible. • Educational initiatives designed to encourage members to receive age/gender appropriate preventive care services. • Comprehensive Health Management programs for diabetes and asthma that offer: – Valuable information from HealthPlus every three months – Seminars related to your illness, given by qualified professionals – Enrollment in a program tailored especially to your needs • Some benefits you may expect from participation include: – A healthier, more active lifestyle – Reduce sysmptons – Fewer emergency room, urgent care visits, or hospitalizations – Support from qualified professionals to help you manage your illness	Nothing
Not covered: • *Premarital exams or classes*	*All charges*

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar deductible
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity – If Medically Necessary and if prior approval is given by your Primary Care Physician, your Specialist Physician, and us. • Orthognathic surgery prior to the age of twenty-one (21) for congenital defects directly affect the growth, development, and function of the jaw Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of condtions of the foot; see foot care*	*All charges*

Reconstructive surgery	You Pay

• 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 on the other breast;
  ●● 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.
	Nothing

Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.* • *Surgeries related to sex transformation* • *Other services and procedures for Cosmetic purposes, such as procedures to correct baldness or wrinkling.* • *Wigs, prosthetic hair, hair transplants, or other procedures or supplies to enhance hair growth;*	*All charges*
Oral and maxillofacial surgery	**You Pay**
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; • Orthognathic surgery prior to the age of twenty-one (21) for congenital defects directly affecting the growth, development, and function of the jaw; • Hospitalization charges for multiple extractions which must be performed in a Hospital due to a concurrent hazardous medical condition; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing

Oral and Maxillofacial surgery - Continued on next page

Oral and maxillofacial surgery *(Continued)*	**You Pay**
Not covered: ● *Oral implants and transplants* ● *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* ● *Dental care and associated supplies, services, and tests, except as specifically provided in this section.*	*All charges*
Organ/tissue transplants	**You Pay**
Limited to: ● Cornea ● Heart ● Heart/lung ● Lung (single and double) ● Pancreas ● Kidney ● Liver ● Allogeneic (donor) bone marrow transplants ● Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions; acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors. ● National Transplant Program (NTP) – A case manager is assigned upon notification of a member needing a transplant. The physician, member and case manager develop a treatment plan specific to the member's medical needs. We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: ● *Medical expenses incurred by a Member who donates an organ or tissue to a non-Member* ● *Medical expenses incurred by a non-Member who donates an organ or tissue to a Member will only be covered if the non-Member does not have coverage for these services* ● *Implants of artificial organs* ● *Transplants not listed as covered*	*All charges*

Anesthesia	You Pay
Professional services provided in – ● Hospital (inpatient)	Nothing
Professional services provided in – ● Hospital outpatient department ● Skilled Nursing Facility ● Freestanding Emergency Center ● Office	Nothing

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, Your costs for covered services for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: • ward, semiprivate, or intensive care accommodations • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home drugs • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing

Inpatient hospital - Continued on next page

Inpatient hospital *(Continued)*	**You Pay**
Not covered ● *Custodial or domiciliary care, basic care, or housekeeping* ● *Non-covered facilities, such as nursing homes, extended care facilities, schools* ● *Services or products provided by Convalescent Homes, Homes for the Aged, or Adult Foster Care Facilities* ● *Personal comfort items such as telephone, television, barber services, guest meals and beds* ● *Private duty nursing, unless Medically Necessary* ● *Blood and blood derivatives not replaced by the Member*	Nothing

Outpatient hospital or ambulatory surgical center	**You Pay**
● 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 ● Dressing, casts, and sterile tray services ● Medical supplies, including oxygen ● Anesthetic and anesthesia service NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: ● *Custodial or domiciliary care, basic care, or housekeeping* ● *Personal comfort or convenience items such as television and telephone services* ● *Blood and blood derivatives not replaced by the member* ● *Private duty nursing*	*All charges*

Extended care benefits/skilled nursing care facility benefits	You Pay
Benefits for care in a Skilled Nursing Facility shall be limited to a maximum of one hundred (100) days per Member per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.	Nothing
Not covered: ● *Custodial or domiciliary care, basic care, or housekeeping* ● *Personal comfort or convenience items such as television and telephone services* ● *Private duty nursing services* ● *Blood and blood derivatives not replaced by the member*	*All charges*

Hospice care	You Pay
Hospice services provided by a Hospice under the direction of a Plan doctor who certifies that the member is in the terminal stages of illness, with a life expectancy of approximately six months or less. Services must be ordered by your Primary Care Physician and authorized in advance by us. Services are limited to: ● Room and board charges ● Medical supplies, drugs and medicines ● Medical-social services	Nothing
Not covered: ● *Custodial or domiciliary care, basic care, or housekeeping* ● *Personal comfort or convenience items such as television and telephone services* ● *Private duty nursing services* ● *Skilled Nursing Services provided on a twenty-four (24) hour basis in the home*	*All charges*

Ambulance	You Pay
Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

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

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

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

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

Note: We reserve the right not to pay for non-emergency treatment received at emergency facilities. If you are hospitalized at Non-Affiliated Hospital, you may be transferred to an Affiliated Hospital upon request of your Primary Care Physician as soon as it is medically appropriate in the opinion of the attending physician. Should you, or your designee, refuse a transfer to an Affiliated Hospital, continued care provided to you at a Non-Affiliated Hospital shall not constitute Covered services and shall no longer be the financial responsibility of us. Coverage for Emergency Health Services provided by a Non-Affiliated Provider shall be limited to a Reasonable Charge for said services. Follow-up Visits to Non-Affiliated Providers of Emergency Health Services within the Service Area shall be limited to two (2) Visits within thirty (30) days of the emergency. Follow-up Visits to Non-Affiliated Providers of Emergency Health Services outside the Service Area shall be limited to two (2) Visits within thirty (30) days of the emergency, or the number of Visits specified in a treatment plan approved by us.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctor's services NOTE: Emergency care urgent care center and hospital copay waived if you are admitted to a hospital.	$10 per visit $25 per visit $25 per visit
Not covered: • *Elective care or non-emergency care* • *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* • *Blood and blood derivatives not replaced by the member*	*All charges*
Emergency outside our service area	**You Pay**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctor's services NOTE: Emergency care urgent care center and hospital copay waived if you are admitted to a hospital.	Nothing Nothing Nothing
Not covered: • *Elective care or non-emergency care* • *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* • *Blood and blood derivative not replaced by the member*	*All charges*
Ambulance	**You Pay**
Professional ambulance service when medically appropriate	Nothing

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

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
Diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit
• Diagnostic tests	Nothing

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You Pay**
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
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 follow your treatment plan and all the following authorization processes:

We have designated Mental Health/Substance Abuse providers throughout our service area. The program's Preferred Provider Panel is comprised of a select group of psychiatrists, psychologists, social workers and substance abuse providers. You may obtain Mental Health/Substance Abuse services from our Preferred Providers without a referral from your Primary Care Physician. Services from Mental Health/Substance Abuse providers not on our Preferred Provider panel require prior authorization from us.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation

We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

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

IMPORTANT

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

- **Who can write your prescription.** Prescriptions for covered drugs must be written by your Primary Care Physician or by a specialist to whom you have been appropriately referred.
- **Where you can obtain them.** You must fill the prescription at a participating pharmacy. A list of participating pharmacies may be found in our Provider Directory.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. The Plan's drug formulary is based on the effectiveness and costs of drugs. Non-formulary drugs will be covered when prescribed by a Plan doctor. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and name brand drug.
- **These are the dispensing limitations.** Prescription drugs covered by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply. You pay a $5 copay per prescription unit or refill for generic drugs or for name brand drugs when generic substitution is not permissible.
- **When you have to file a claim.** Our members may occasionally receive bills for health care services. This could occur for a number of reasons, such as computer errors or out-of-area emergency treatment. If you receive a bill or statement, or are requesting reimbursement, mail the bills to us within 90 days of the date of service. Please be sure that the bill contains the following information:
  - Patient name
  - Subscriber number and the patient's two-digit relationship code as shown on your identification card (for example: 345123789-01)
  - Amount billed
  - Amount paid
  - Description of service and procedure codes
  - Diagnosis and diagnosis codes
  - Location of service
  - Date of service

  Address the envelope as follows:

  HealthPlus of Michigan
  Attention: Claims Department
  P. O. Box 1700
  Flint, MI 48501-1700

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

Prescription drug benefits begin on next page

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: ● Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. ● Full range of FDA-approved drugs, prescriptions, and devices for birth control ● Insulin and insulin syringes ● Diabetic testing reagents and supplies, including glucose test strips, test tape, and alcohol swabs ● Smoking cessation drugs and medications; limited to one course of therapy every two years when prescribed by the Plan doctor or psychiatrist and accompanied by enrollment in a smoking cessation program approved by the Plan doctor or psychiatrist ● Disposable needles and syringes for the administration of covered medications ● Drugs for sexual dysfunction (see next page) ● Intravenous fluids and medication for home use, and some injectable drugs are covered under medical and surgical benefits. ● Fertility drugs (when used in conjunction with prior authorized treatment plan)	$5 per unit or refill

Covered medications and supplies - Continued on next page

Covered medications and supplies *(Continued)*	**You Pay**
Here are some things to keep in mind about our prescription drug program: ● Prescription Drugs: Benefits for Prescription Drugs in our formulary will be limited to the reasonable cost of generically available products, unless no generically equivalent product exists or a Member-specific review for medical necessity by us determines the need for brand name medication. We reserve the right to determine generic equivalency of products available to HPM Members. We reserve the right to review Prescription Drug products and procedures for medical necessity efficacy of use and quality to determine if they should be available to HPM Members. ● Prescription Drugs for Treatment of Impotency: Benefits for Prescription Drugs for the treatment of impotency in males 35 years of age or older shall be limited to those who have a diagnosis of erectile dysfunction. Benefits for Prescription Drugs for the treatment of impotency in males under 35 years of age shall be limited to those who meet HPM medical necessity criteria and whose Primary Care Physician or participating treating urologist has obtained prior authorization from HPM. Coverage for both age groups shall be limited to fifty percent (50%) of covered charges and shall not exceed six (6) doses per thirty (30) day period and shall be limited to the original prescription and up to two (2) refills prior to follow up with the treating physician. There shall be no coverage for replacement of lost, stolen, or destroyed medication.	$5 per prescription
Not covered: ● *Drugs and supplies for cosmetic purposes* ● *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* ● *Nonprescription medicines (or their Prescription Drug equivalents)* ● *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* ● *Medical supplies as dressings and antiseptics* ● *Drugs to enhance athletic performance*	*All charges*

Section 5 (g). Special Features

Feature	Description
NCQA "Excellent Accreditation"	We have been awarded "Excellent Accreditation" status – the highest level possible – by the National Committee for Quality Assurance (NCQA). NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's health care.
High risk pregnancies	A case manager is assigned upon notification of a high risk pregnancy. The physician, member, and case manager develop a treatment plan specific to the member's medical needs.
Centers of excellence for transplants/heart surgery/etc	The following are Centers of excellence available when appropriately referred: – Cleveland Clinic Foundation – University of Michigan
HealthQuest Health Resource Library	The Health Resource Library is a service dedicated to providing our members with a wide range of health information. Our library is stocked with over 200 books, videos, audiocassettes, and pamphlets that can be checked out just like at a public library, but in the comfort of your home. This is a free service; we even pay for all the postage. To learn more about the Health Resource Library, call the HealthQuest Program at (800) 345-9956, extension 1943 and select option 5.
College Students	Eligible college students are covered for emergency illnesses or injuries that occur when they are out of the service area.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians or dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; 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.

IMPORTANT

Accidental injury benefit	**You Pay**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing

Dental benefits	**You Pay**
We have no other dental benefits.	

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this plan;
- Services, drugs, or supplies that are 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 when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Court-ordered tests, reports, or treatment, unless authorized by the Member's Primary Care Physician;
- Charges for transportation and/or lodging which may be required to receive Covered Services.

Section 7. Filing a claim for covered services

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

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

Medical, hospital, and drug benefits

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

When you must file a claim — such as for out-of-area care — submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

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

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

Deadline for filing your claim

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description

1 Ask us in writing to reconsider our initial decision. Write to us at: 2050 South Linden Road, P. O. Box 1700, Flint, MI 48501-1700. You must:

(a) Write to us within 6 months from the date of our decision; and
(b) Send your request to us at: 2050 South Linden Road, P. O. Box 1700, Flint, MI 48501-1700; and
(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
(d) Include copies documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

2 We have 30 days from the date we receive your request to:

(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
(b) Write to you and maintain our denial –go to step 4; or
(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

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

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision

4 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians'letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, 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 provide a copy of your specific written consent with the review request.

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

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

6 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. This is the only deadline that may not be extended.

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

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

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

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

(b) We denied your initial request for care or preauthorization/prior approval, then:
- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division III at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-State Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

- **The Original Medicare Plan**

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required.

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

(Primary payer chart begins on next page.)

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

Primary Payer Chart		
A. When either you — or your covered spouse — are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or ……...….	✓	
b) The position is not excluded from FEHB…….....		✓
Ask your employing office which of these applies to you.		
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers'Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you — or a covered family member — have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or…….....	✓	
b) Are an active employee……..		✓

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

Claims process — You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.

- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at (800) 332-9161 or visit our website at www.healthplus.com.

We waive some costs when you have Medicare — When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive after member copayment Part B deductible, 20% of Medicare approved amounts and Part B excess charges.

- **Medicare managed care plan** If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

  This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

  This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, but we will not waive any of our out-of-pocket costs.

  Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare managed care plan. 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+Choice service area.

- **Enrollment in Medicare Part B**

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 benefits. You must use our providers.

Medicaid

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

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.

Section 10. Definitions of terms we use in this brochure

Acute Care Service — The provision of highly concentrated care to patients requiring comprehensive observation, continuous monitoring, and treatment with immediate Physician intervention when necessary due to the seriousness or unstable nature of the illness or injury.

Affiliated Provider — A provider who has agreed in writing to provide services to Members.

Appropriately Referred — That situation when a referral is issued on behalf of a Member from that Member's Primary Care Physician to another Provider, or from a Physician to whom a Member is referred to another Provider, if such referrals are consistent with HPM's referral policy.

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

Copayment — When expressed as a dollar sum, the amount each Member must pay per Visit to a treating Provider in connection with Health Care Benefits. Copayment, when expressed as a percentage, means the portion of Reasonable Charge which each Member must pay per Visit to a treating Provider.

Day Treatment Mental Health And/or Substance Abuse Services — Generally accepted therapeutic services and/or ancillary services which last four (4) or more consecutive hours.

Dental Care — Services or procedures which concern maintenance or repair of the teeth and/or gums or are performed to prepare the mouth for dentures.

Dentist — An individual licensed under the Act or any licensing statute or law of the applicable governing state or governmental unit to engage in the practice of dentistry.

Durable Medical Equipment — Equipment of the type approved by HPM which is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness or injury.

Experimental — A service is of doubtful medical usefulness or effectiveness to the Member, as assessed by local medical community standards.

Freestanding Emergency Center — A Facility which is licensed, certified, or otherwise authorized pursuant to the Act or any similar licensing statute or law of its governing state or governmental unit to provide services in emergencies or after hours.

Hearing Aid — An electronic device of the type approved by HPM worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mold, if Medically Necessary.

Home Health Agency — A facility or program which is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit and is approved to provide home health services.

Hospice

A Provider which is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit to supply pain relief, symptom management, and supportive services to individuals suffering from a disease or condition with a terminal prognosis.

Hospital

An acute care general facility which: (1) provides inpatient diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of duly licensed Physicians; (2) is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit; and (3) which is not, other than incidentally, a place of rest, a place for the aged, a nursing home, or a facility for the treatment of substance abuse or pulmonary tuberculosis.

In-Network Benefits

The provision of Covered Services by: (A) The Member's Primary Care Phsycian; (B) A Provider to whom the Member is Appropriately Referred; or (C) An Affiliated Provider when a referral or other authorization is not required by HPM.

Intermediate Care

As it applies to Mental Health and Substance Abuse Services, the use of a full or partial residential therapy setting (also known as Residential and Day Treatment programs), and shall include generally accepted therapeutic techniques and other therapeutic and ancillary services.

Intermittent Skilled Nursing Care

Services provided by a licensed nurse to a Member who has a medically predictable recurring need for skilled care at least once in every sixty (60) day period.

Medically Necessary

The health care associated with the Member is consistent with and called for in relationship to the intensity of service, severity of illness, and appropriateness of services provided.

Medicare

Title XVIII of the Social Security Act and all amendments thereto.

Members

The Subscriber and his/her Dependents covered under this Contract.

Non-Affiliated Provider

A Provider who has not agreed in writing to provide services to Members.

Non-Plan Physician

A Physician who has not entered into a written contract to provide services to Members.

Non-Preferred Mental Health Provider

An Affiliated Provider specializing in the treatment of mental illness who is not designated by HPM as a Preferred Provider.

Non-Preferred Substance Abuse Provider

An Affiliated Provider specializing in the treatment of substance abuse who is not designated by HPM as a Preferred Provider.

Orthotic Appliance

An apparatus of the type approved by HPM which is used to support, align, prevent, or correct deformities, or to improve the function of movable parts of the body.

Out-of-Network Benefits

The provision of Covered Services by: (A) A Non-Affiliated Provider, unless Appropriately Referred; (B) An Affiliated Provider (other than the Member's Primary Care Physician) to whom the Member was not Appropriately Referred; or (C) A Provider under any other circumstances which does not meet the definition of an In-Network Benefit.

Outpatient Mental Health And/or Substance Abuse Services

Therapeutic services which last less than (4) consecutive hours.

Pharmacy

A business licensed under the Act or similar licensing statute or law of its governing state or governmental unit to engage in the practice of pharmacy.

Physician

An individual licensed under the Act or other similar licensing statute or law of the applicable governing state or governmental unit to engage in the practice of allopathic medicine, osteopathic medicine, chiropractic, or podiatric medicine and surgery.

Plan Physician

Any Physician who has entered into a written contract to provide services to Members.

Preferred Mental Health Provider

An Affiliated Provider specializing in the treatment of mental illness who is both selected by a Member for his/her care and is designated by HPM as a Preferred Mental Health Provider.

Preferred Substance Abuse Provider

An Affiliated Provider specializing in the treatment of substance abuse who is both selected by a Member for his/her care and is designated by HPM as a Preferred Substance Abuse Provider.

Prosthetic Device

A device that replaces all or a part of an internal body organ or external body member, or that replaces all or a part of the function of a permanently inoperative or malfunctioning internal body organ or external body member.

Provider

A health professional, facility, or agency complying with the Act or other similar licensing statute of the applicable governing state or governmental unit. The following services are not covered: Services which are provided by individuals who are not licensed/certified under the Michigan Public Health Code (or other similar code/statute of any other state or government unit) or services which are beyond the treating individual's licensing.

Reasonable Charge

The lesser of the treating Provider's charge or the amount determined to be a fair charge by HPM in comparison to charges of other Providers in the same geographic region.

Residential Substance Abuse Program

A course of treatment which requires twenty-four (24) hour on-site presence coupled with the continuous availability of intense drug and alcohol therapy.

Semi-Private Room

A room containing two (2) or more patient beds in an inpatient facility.

Short-Term

Service for a condition which HPM determines can be expected to significantly improve within a period of sixty (60) days.

Skilled Care Service — Concentrated observation, monitoring, evaluation, and intervention by licensed and trained personnel under the direction of a Physician and usually does not require daily intervention for conditions that are stable or stabilizing.

Skilled Nursing Facility — A facility licensed to provide Skilled Nursing Care in accordance with the Act or other similar licensing statute of its governing state or governmental unit.

Specialist Physician — A Plan or Non-Plan Physician to whom a Member is Appropriately Referred.

Us/We — Us and we refers to *HealthPlus of Michigan*

Visit — A meeting between a Member and Provider for the purpose of rendering Covered Services, without regard to the frequency of meetings if each such meeting is separated by any period of time.

You — You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that 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. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

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

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

Types of coverage available for you and your family

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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.

  You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. 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 Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **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.

  You may not elect TCC if you are fired from your Federal job due to gross misconduct.

  Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

● 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

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.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at (800) 332-9161 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

NOTES:

Summary of benefits for the HealthPlus of Michigan - 2001

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	13
Services provided by a hospital:		
• Inpatient.....	Nothing	26
• Outpatient.....	Nothing	27
Emergency benefits:		
• In-area.....	$25 per visit	30
• Out-of-area.....	Nothing	30
Mental health and substance abuse treatment.....	Regular cost sharing.	31
Prescription drugs.....	$5 copay per unit or refill	34
Dental Care (Accidental injury benefit only).....	Nothing	37
Vision Care.....	No benefit.	18
Special features: • NCQA “Excellent” Accreditation • High risk pregnancies • Centers of Excellence • HealthQuest and Health Resource Library • College Students		36
Protection against catastrophic costs (your out-of-pocket maximum).....	Your out-of-pocket expenses covered under this plan are limited to stated copayments that are required for a few benefits.	11

2001 Rate Information for
HealthPlus of Michigan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Greater Flint and Saginaw Areas							
Self Only	X51	$81.68	$27.23	$176.98	$58.99	$96.66	$12.25
Self and Family	X52	$195.82	$71.16	$424.28	$154.18	$231.17	$35.81