HealthPlus of Michigan

http://www.healthplus.com

2004

A Health Maintenance Organization

Serving: Greater Flint and Saginaw areas

Enrollment in this Plan is limited. You must live in our Geographic service area to enroll. See page 9 for requirements.

This Plan has Excellent accreditation from the NCQA. See the 2004 Guide for more information on accreditation.

Enrollment codes for this Plan:

X51 Self Only
X52 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Center for
Retirement and Insurance Service
http://www.opm.gov/insure

Federal Employees
Health Benefits Program

RI 73-648

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season – especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this brochure, our FEHB Guide, and our web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on www.opm.gov/insure!

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's HealthierFeds campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your healthcare needs. Use this brochure, the FEHB Guide, and the web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative).
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.
- To laws enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations).
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.

- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call (202) 606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change.

Table of Contents

Introduction

This brochure describes the benefits of HealthPlus of Michigan under our contract (CS 2712) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for HealthPlus of Michigan administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2004, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2004, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

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

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the United States Office of Personnel Management, Insurance Services Program, Planning and Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (I.D.) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at (800) 332-9161 and explain the situation.
  - If we do not resolve the issue:

CALL — THE HEALTH CARE FRAUD HOTLINE
202/418-3300
OR WRITE TO:
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415-1100

  - Do not maintain as a family member on your policy:
    - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - Your child over age 22 (unless he/she is disabled and incapable of self support).
  - If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
  - You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an elibigle member or who is no longer enrolled in the Plan.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**
   - Ask questions and make sure you understand the answers.
   - Choose a doctor with whom you feel comfortable talking.
   - Take a relative or friend with you to help you ask questions and understand answers.
2. **Keep and bring a list of all the medicines you take.**
   - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
   - Tell them about any drug allergies you have.
   - Ask about side effects and what to avoid while taking the medicine.
   - Read the label when you get your medicine, including all warnings.
   - Make sure your medicine is what the doctor ordered and know how to use it.
   - Ask the pharmacist about your medicine if it looks different than you expected.
3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of test or procedures.
   - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
   - Call your doctor and ask for your results.
   - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
   - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, "Who will manage my care when I am in the hospital?"
   - Ask your surgeon:
     - Exactly what will you be doing?
     - About how long will it take?
     - What will happen after surgery?
     - How can I expect to feel during recovery?
   - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

➢ www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.

➢ www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

➢ www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's healthcare delivery system.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You 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 hundreds of doctors who specialize in Family Practice, Internal Medicine, or Pediatrics. The listing for each Primary Care Physician also shows a "primary hospital." This is the hospital where your Primary Care Physician will direct you for hospital services in most instances. When you select a Primary Care Physician, you also are agreeing to use the hospital listed.

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

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

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, 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 Federal brochure
  - Covered benefits, including prescription drug coverage
  - Description of emergency health coverages and benefits
  - Out-of-area coverage and benefits
  - An explanation for copayments and any other out-of-pocket expense

- Continuity of treatment
  - Arrange for the continuation of treatment by that provider; or
  - Assist the member in selecting a new provider
- Additional information
  - Provider information
  - Physician credentials
  - Physician status/discipline
  - Specific benefits
  - Financial arrangement with physicians
  - Who to contact
- Years in existence
- Profit status

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

Service Area

To enroll in this plan, 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 benefits. We will not pay for any other health care services out of our service area unless the services have prior approval.

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

Section 2. How we change for 2004

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

Program-wide changes

- We added information regarding two new Federal Programs that complement FEHB benefits, the Federal Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program. *See pages 58-61.*
- We added information regarding Preventing Medical Mistakes. *See page 6.*
- We added information regarding enrolling in Medicare. *See page 45.*
- We revised the Medicare Primary Payer Chart. *See page 47.*

Changes to this Plan

- Your share of the non-Postal premium will increase by 36.1% for Self Only or 7.3% for Self and Family.
- Prescription drug copayments are now $10 for generic drugs and $20 for brand-name drugs. Previously, you paid $5 for generics and $10 for brand-name drugs.
- We have added a new Mail Order prescription drug benefit that covers a 35-90 day supply subject to a $20 copayment for generics and a $40 copayment for brand-name drugs.
- Out-of-area emergency benefits copayments are now $10 per doctor's office visit, $25 per urgent care visit and $25 per hospital visit. Previously, you paid no copayments.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 332-9161 or write to us at P.O. Box 1700, Flint, MI 48501-1700.

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 to get covered care

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

- **Specialty care**

Your Primary Care Physician will refer you to a specialist for needed care. When you receive a referral from your Primary Care Physician, you must return to the Primary Care Physician after the consultation, unless your Primary Care Physician authorized a certain number of visits without additional referrals. The Primary Care Physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your Primary Care Physician gives you a referral. You may see a participating mental health or substance abuse provider for an initial office visit without a referral, but continued coverage is dependent upon approval of the provider's treatment plan. Females may see a participating obstetrician or gynecologist for a well-woman exam once per year without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your Primary Care Physician will work with the specialist and us to develop a treatment Plan that allows you to see your specialist for a certain number of visits without additional referrals. Your Primary Care Physician will use our criteria when creating your treatment Plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your Primary Care Physician. Your Primary Care Physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your Primary Care Physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic 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. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

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

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

Section 4. Your costs for covered services

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

• **Copayments**	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive 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 catastrophic protection out-of-pocket maximum	We have no out-of-pocket maximum. Your out-of-pocket expenses covered under this Plan are limited to stated copayments that are required for a few benefits.

Section 5. Benefits — OVERVIEW

(See page 10 for how our benefits changed this year and page 63 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. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, 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 office visit
● In an urgent care center	$25 per visit
● During a hospital stay	Nothing
● In a skilled nursing facility	Nothing
● Initial examination of a newborn child covered under a family enrollment by the Member's Primary Care Physician	Nothing if examination occurs during hospital stay; otherwise, $10 per visit
● Office medical consultations	$10 per office visit
● Second surgical opinion	$10 per office 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: ● Total Blood Cholesterol – once every three years ● Colorectal Cancer Screening, including — Fecal occult blood test — Sigmoidoscopy, screening – once every five years starting at age 50	$10 per office visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	$10 per office 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 office visit
Routine mammogram – covered for women age 35 and older, as follows: ● Baseline by the age of 40 ● From age 40 through 49, one mammogram every one or two years ● At age 50, one yearly	$10 per office visit
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, ages 19 and over (except as provided for under Childhood immunizations) ● Influenza vaccine annually ● Pneumococcal vaccine, age 65 and over	Nothing
Preventive care, children	**You Pay**
● Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
● Well-child care charges for routine examinations, immunizations and care (under age 22) ● Examinations, such as: — Eye exams through age 17 to determine the need for vision correction. — Ear exams through age 17 to determine the need for hearing correction. — Examinations done on the day of immunizations (under age 22).	$10 per office 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 11 for other circumstances, such as extended stays for you or your baby. ● You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. ● We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Note: (Surgical benefits, not maternity benefits, apply to circumcision.) ● We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 for initial visit; nothing thereafter
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*

Family planning	You Pay
A range of voluntary family planning services, limited to: ● Voluntary sterilization (see surgical procedures Section 5 (b)) ● Surgically implanted contraceptives (such as Norplant) ● Injectable contraceptive drugs (such as Depo provera) ● Intrauterine devices (IUDs) ● Diaphragms ● Medically-indicated genetic testing and counseling per generally accepted medical practice Note: We cover oral contraceptives under the prescription drug benefit.	Nothing
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, GIFT and zygote ZIFT* — *Zygote transfer* ● *Services and supplies related to excluded ART procedures* ● *Reversal of a voluntary sterilization and all associated costs* ● *Pre-embryo cryo preservation techniques and associated services* ● *Infertility services if one of the partners has previously undergone surgical sterilization or if one of the partners is menopausal or post menopausal* ● *All services related to a surrogate parenting arrangements of any kind* ● *Cost of donor sperm and all associated costs* ● *Cost of donor egg*	*All charges*

Allergy care	You Pay
Testing and treatment	$10 per office visit
Allergy injection	Nothing; $10 office visit copay may apply.
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 25. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We will only cover GHT when we preauthorize the treatment. Your 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 our Medical Director to determine medical necessity. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See services requiring our prior approval in Section 3.	$10 per office visit

Physical and occupational therapies	You Pay
• Two consecutive months per condition are covered if significant improvement can be expected within the two months. Services are covered for each of the following: — qualified physical therapists and — occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is covered with no visit limits.	Nothing
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *vocational rehabilitation services*	*All charges*
Speech therapy	**You Pay**
• 60 visits per condition	Nothing
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 office visit
Eye exam to determine the need for vision correction for children through age 17. (See Preventive Care, Children)	$10 per office visit
Not covered: ● *Refractions* ● *Eyeglasses or contact lenses and, examinations for them* ● *Eye exercises and orthoptics* ● *Radial keratotomy and other refractive surgery* ● *Eyeglasses for ocular injury*	*All charges*
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 office 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.* ● *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**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

Orthopedic and prosthetic devices *(continued)*	**You Pay**
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 devices when they do not replace a limb or other part of the body after accidental or surgical removal and/or when your body growth necessitates a replacement.*	*All charges*
Durable medical equipment (DME)	**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 practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Personal comfort or convenience items such as television and telephone services* • *Skilled nursing services provided on a twenty-four (24) hour basis in the home* • *Private duty nursing services (except if medically necessary in an inpatient hospital setting).*	*All charges*

Chiropractic	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 office visit
Not covered: • *Hypnosis* • *Biofeedback* • *Acupuncture*	*All charges*
Alternative treatments	**You Pay**
No benefit	*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 – Reduced symptoms – 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 year deductible
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)
- YOUR PHYSICIAN MUST GET PRECERTIFICATION 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	
A comprehensive range of services, such as: ● Operative procedures ● Treatment of fractures, including casting ● Normal pre- and post-operative care by the surgeon ● Correction of amblyopia and strabismus ● Endoscopy procedures ● Biopsy procedures ● Removal of tumors and cysts ● Correction of congenital anomalies (see reconstructive surgery) ● Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over ● Orthognathic surgery prior to the age of twenty-one (21) for congenital defects directly affecting the growth, development, and function of the jaw ● Insertion of internal prosthetic devices. See 5(a) Orthopedic and prosthetic devices for device coverage information.	Nothing

Surgical procedures *(continued)*	**You Pay**
• Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions 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
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. ● Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas	Nothing

Organ/tissue transplants *(continued)*	**You Pay**
• 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. Note: 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 Sections 5(a) or (b).
- **YOUR PHYSICIAN 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, schools* ● *Services or products provided by Convalescent Homes, Homes for the Aged, or Adult Foster Care Facilities* ● *Personal comfort items such as telephone, television, barber services, guest meals and beds* ● *Private duty nursing, unless medically necessary* ● *Blood and blood derivatives not replaced by the Member*	*All charges*

Outpatient hospital or ambulatory surgical center	**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* ● *Independent nursing, homemaker services* ● *Personal comfort or convenience items such as television and telephone services* ● *Private duty nursing services* ● *Skilled Nursing Services provided on a twenty-four (24) hour basis in the home*	*All charges*
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 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

What is a medical emergency?

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

What to do in case of emergency:

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

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

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

Benefit Description	You Pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center, including doctor's services • 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 office visit $25 per visit $25 per visit
Not covered: • *Elective care or non-emergency care* • *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, including doctor's services • 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 office 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 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

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

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

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

IMPORTANT

Benefit Description	You Pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other 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 follow all of 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.

For coverage of mental health and substance abuse services, you may access your benefits in any of the following ways:

1. Call the HealthPlus Behavioral Service department at (800) 555-5025.

2. Contact a panel provider from the HealthPlus Provider Directory and schedule an appointment. The provider you select will obtain the referral.

3. Contact your Primary Care Physician to coordinate your care.

Because our preferred panel of providers changes periodically, you may want to obtain an updated list by calling our Behavioral Services department at (800) 555-5025.

Limitation

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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 and are payable only when we determine they are medically necessary.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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 may fill the prescription at a participating pharmacy, or through Express Scripts. A list of participating pharmacies may be found in our Provider Directory. If you have questions about mail order pharmacy services, call HealthPlus at (800) 332-9161 or Express Scripts at (877) 322-8471
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. The Plan's drug formulary is based on the effectiveness and costs of drugs. Non-formulary drugs will be covered when prescribed by a Plan doctor. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a brand-name drug), but you request the brand-name drug, you pay the price difference between the generic and brand-name drug in addition to the generic copayment.
- **These are the dispensing limitations.** Prescription drugs covered by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for a 34-day supply. You pay a $10 copay per prescription for generic drugs or a $20 copay per prescription for brand-name drugs. Mail order prescription drugs covered by a Plan or referral doctor and obtained through Express Scripts may be dispensed for up to a 90-day supply, for which you will pay two times the normal copayment per perscription (i.e.: $20 for a 90-day supply of generic drugs, and $40 for a 90-day supply of brand name drugs). If no generic equivalent is available, you will still be required to pay the brand-name copayment. Members called to active duty in a time of national or other emergency who need to obtain a greater-than-normal supply of prescribed medications should call our Customer Service Department at (800) 332-9161.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. Using the most cost-effective medication saves money. However, you and your physician have the option to request a brand-name even if a generic option is available. You will have to pay the difference between the cost of the generic and the brand-name drug in addition to the generic copayment.
- **When you have to file a claim.** Our members may occasionally receive bills for health care services. This could occur for a number of reasons, such as computer errors or out-of-area emergency treatment. If you receive a bill or statement, or are requesting reimbursement, mail the bills to us within 90 days of the date of service. Please be sure that the bill contains the following information:
  - — Patient name
  - — Subscriber number and the patient's two-digit relationship code as shown on your identification card (for example: 345123789-01)
  - — Amount billed
  - — Amount paid

Prescription drug benefits begin on next page

- **When you have to file a claim.** (*continued)*

— 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.

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) ● Growth hormone	**Retail pharmacy** $10 per generic drug $20 per brand-name drug **Mail Order (35-90 day supply)** $20 per generic drug $40 per brand-name drug

Covered medications and supplies - Continued on next page

Covered medications and supplies *(continued)*	**You Pay**
Here are some things to keep in mind about our prescription drug program: ● Benefits for Prescription Drugs in our formulary will be limited to the reasonable cost of generically available products, unless no generically equivalent product exists or a Member-specific review for medical necessity by us determines the need for brand name medication. We reserve the right to determine generic equivalency of products available to HPM Members. We reserve the right to review Prescription Drug products and procedures for medical necessity, efficacy of use, and quality to determine if they should be available to HPM Members.	
● Prescription Drugs for Treatment of sexual dysfunction: Coverage is limited to **fifty percent** (50%) of covered charges and will not exceed six (6) doses per thirty (30) day period and will be limited to the original prescription and up to two (2) refills prior to follow up with the treating physician.	50% per unit or refill
Not covered: ● *Drugs and supplies for cosmetic purposes* ● *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* ● *Nonprescription medicines (or their Prescription Drug equivalents)* ● *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* ● *Medical supplies such as dressings and antiseptics* ● *Drugs to enhance athletic performance* ● *Replacement of lost, stolen, or destroyed medication.*	*All charges*

Section 5 (g). Special features

Feature	Description
NCQA "Excellent" accreditation	We have been awarded "Excellent" Accreditation status for our Commercial HMO – the highest level possible by the National Committee for Quality Assurance (NCQA). NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's health care.
High risk pregnancies	A case manager is assigned upon notification of a high risk pregnancy. The physician, member, and case manager develop a treatment plan specific to the member's medical needs.
Disease management program	If you have diabetes, asthma or certain heart diseases, you may be eligible to participate in our Disease Management Program. The program is designed to help you better understand and manage your condition, so you can enjoy improved health and quality of life. Ask your physician to refer you, or contact us at (800) 332-9161 for more information.
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. Contact us at (800) 332-9161 for eligibility requirements.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. ● We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. ● Alternative benefits are subject to our ongoing review. ● By approving an alternative benefit, we cannot guarantee you will get it in the future. ● The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. ● Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.

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. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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	
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; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

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

Medical, 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 services you receive outside of the Plan's service area — submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

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

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

Deadline for filing your claim

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny 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. 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: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, D.C. 20415-3630. Send OPM the following information: ● A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; ● Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; ● Copies of all letters you sent to us about the claim; ● Copies of all letters we sent to you about the claim; and ● Your daytime phone number and the best time to call. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

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

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

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

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage 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-Stage 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number (800) 772-1213 to set up an appointment to apply. If you do not apply for one or both Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + 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 (Part A or Part B)**

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

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

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

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

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

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

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

(Primary payer chart begins on the next page.)

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payer for the individual with Medicare is…**	
	Medicare	**This Plan**
1) Are an active employee with the Federal government and… • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
2) Are an annuitant and… • You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case)	✓*	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and… • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) 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)	✓*	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) 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)	✓**	
B. When you or a covered family member…		
1) Have Medicare solely based on end stage renal disease (ESRD) and… • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and… • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or your spouse are eligible for Medicare solely due to disability and you		
1) Are an active employee with the Federal government and… • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
2) Are an annuitant and… • You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
D. Are covered under the FEHB Spouse Equity provision as a former spouse	✓	

* Unless you have FEHB coverage through your spouse who is an active employee

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

- **Medicare + Choice**

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

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

This Plan and our Medicare + Choice plan: You may enroll in our Medicare+ Choice plan and also remain enrolled in our FEHB plan. In this case, we do not waive cost-sharing for your FEHB coverage.

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Acute Care Service	The provision of highly concentrated care to patients requiring comprehensive observation, continuous monitoring, and treatment with immediate Physician intervention when necessary due to the seriousness or unstable nature of the illness or injury.
Affiliated Provider	A provider who has agreed in writing to provide services to Members.
Appropriately Referred	That situation when a referral is issued on behalf of a Member from that Member's Primary Care Physician to another Provider, or from a Physician to whom a Member is referred to another Provider, if such referrals are consistent with the Plan's referral policy.
Calendar year	January 1 through December 31 of the same year.
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.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Short term, Non-skilled care, furnished for the purpose of meeting non-medically necessary personal needs, such as assistance in walking, dressing, bathing, eating and taking medications. Custodial care lasting 90 days or more is sometimes known as Long term care, neither of which are covered by this Plan.
Day Treatment Mental Health And/or Substance Abuse Services	Generally accepted therapeutic services and/or ancillary services which last four (4) or more consecutive 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 the Plan which is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness or injury.
Experimental or investigational services	A service that is of doubtful medical usefulness or effectiveness to the Member, as assessed by local medical community standards.
Freestanding Emergency Center	A Facility which is licensed, certified, or otherwise authorized pursuant to the Act or any similar licensing statute or law of its governing state or governmental unit to provide services in emergencies or after hours.
Hearing aid	An electronic device of the type approved by HPM worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mold, if medically necessary.

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

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

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

In-Network Benefits The provision of Covered Services by: (A) The Member's Primary Care 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 the Plan.

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

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

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

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

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

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

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

Non-Preferred Mental Health Provider An Affiliated Provider specializing in the treatment of mental illness who is not designated by the Plan as a Preferred Provider.

Non-Preferred Substance Abuse Provider An Affiliated Provider specializing in the treatment of substance abuse who is not designated by the Plan as a Preferred Provider.

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

Out-of-Network Benefits

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

Outpatient Mental Health And/or Substance Abuse Services

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

Pharmacy

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

Physician

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

Plan Physician

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

Preferred Mental Health Provider

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

Preferred Substance Abuse Provider

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

Prosthetic Device

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

Provider

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

Reasonable Charge

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

Residential Substance Abuse Program

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

Semi-Private Room

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

Short-Term

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

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

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

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

Us/We — Us and we 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

Coverage information

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 your FEHB coverage. These materials tell you:

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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2004 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2003 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

● When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage. (TCC, or a conversion policy (a non-FEHB individual policy.)

● 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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPMs website, www.opm.gov/insure.

● Temporary continuation of coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal 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. It explains what you have to do to enroll.

● Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI-79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked question. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Two new Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you know about two new Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20 to more than 40 percent on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program** (FLTCIP) covers long term care costs not covered under the FEHB.

The Federal Flexible Spending Account Program - FSAFEDS

● What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%!!*

There are two types of FSAs offered by the FSAFEDS Program:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. ***Note:*** The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is $3,000 annually. The minimum amount is $250 annually.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is $5,000 annually. The minimum amount is $250 annually. ***Note:*** The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is $5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is $2,500 per year. The limit includes any child care subsidy you may receive

● Enroll during Open Season

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!

- Enroll online anytime during Open Season (November 10 through December 8, 2003) at **www.fsafeds.com**.
- Call the toll-free number 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time and a FSAFEDS Benefit Counselor will help you enroll.

- **What is SHPS?**

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and will be responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you're not enrolled in FEHB– you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the "use-it-or-lose-it" rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFEDS during this Open Season.

The **FSAFEDS Calculator** at www.fsafeds.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 63 and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

Under this Plan, typical out-of-pocket expenses include office visit copays, prescription drug copays and emergency care copays. Common expenses not covered by us include glasses, laser vision surgery and hearing aids.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at http://www.irs.gov/pub/irs-pdf/p502.pdf. If you do not see your service or expense listed in Publication 502, please call a FSAFEDS Benefit Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

● Tax savings with an FSA

An FSA lets you allot money for eligible expenses before your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will also be lower. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	$50,000	$50,000
And you deposit this amount into a FSA:	$ 2,000	-$0-
Your taxable income is now:	$48,000	$50,000
Subtract Federal & Social Security taxes:	$13,807	$14,383
If you spend after-tax dollars for expenses	-$0-	$ 2,000
Your real spendable income is:	$34,193	$33,617
Your tax savings:	**$576**	**-$0-**

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon in which retirement system you are enrolled (CSRS or FERS), as well as your individual tax situation. In this example, the individual received $2,000 in services for $1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

● Tax credits and deductions

You *cannot* claim expenses on your Federal income tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is tax-free from the first dollar. In addition, you may be reimbursed from the HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example listed in the above chart, only health care expenses exceeding $3,750 (7.5% of $50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exception is not available on your Federal income tax return.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

  Probably not. While there is an administrative fee of $4.00 per month for an HCFSA and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFEDS.com web site or call 1-877-FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

- **Contact us**

  To find out more or to enroll, please visit the **FSAFEDS Web site** at **www.fsafeds.com**, or contact SHPS by email or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

  - E-mail: fsafeds@shps.net
  - Telephone: 1-877-FSAFEDS (372-3337)
  - TTY: 1-800-952-0450 (for hearing impaired individuals that would like to utilize a text messaging service)

The Federal Long Term Care Insurance Program

It's important protection

Here's why you should consider enrolling in the Federal Long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive when you need assistance performing activities of daily living – such as bathing or dressing yourself. This need can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent, so you won't have to worry about being a burden to your loved ones.
- **It's to your advantage to apply sooner rather than later.** Long term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

To find out more and to request an application

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

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

NOTES

Summary of benefits for the HealthPlus of Michigan - 2004

- **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	16
Services provided by a hospital:		
● Inpatient.....	Nothing	29
● Outpatient.....	Nothing	30
Emergency benefits:		
● In-area or out-of-area.....	$10 per office visit $25 per urgent care center visit $25 per hospital visit	33
Mental health and substance abuse treatment	Regular cost sharing	34
Prescription Drugs	**Retail pharmacy** $10 generic $20 brand-name **Mail Order** **(35 to 90-day supply)** $20 generic $40 brand-name	37
Dental Care (Accidental injury benefit only)	Nothing	40
Vision Care	No benefit.	22
Special features: ● NCQA "Excellent" Accreditation ● High risk pregnancies ● Disease management program ● Centers of Excellence for transplants/heart surgery, etc. ● HealthQuest and Health resource library ● College students ● Flexible benefits option		39
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	We have no out-of-pocket maximum. Your out-of-pocket expenses covered under this plan are limited to stated copayments that are required for a few benefits.	14

2004 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 a special FEHB guide is published 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	$121.40	$55.49	$263.03	$120.23	$143.32	$33.57
Self and Family	X52	$277.09	$126.87	$600.36	$274.89	$327.12	$76.84