2007 FEHB Proposal Instructions

Preparing Your Benefit Proposal

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

- A plain language description of each proposed change (in worksheet format) and the revised language for your 2007 brochure;

- A plain language description of each proposed clarification (in worksheet format) and the revised language for your 2007 brochure; and

- A signed contracting official's form.

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

Organ/Tissue Transplants Benefits

This year, we have included specific lists of diagnoses and/or conditions for organ/tissue transplants in Attachment I. We have divided Attachment I into three tables as follows:

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

OPM based its organ/tissue coverage requirements on the Blue Cross Blue Shield Association (BCBSA) Technology Evaluation Committee's review of scientific literature and accepted standards of practice within the oncology community. The BCBSA Committee is comprised of a group of clinical physician experts and also includes clinical experts from the Kaiser Permanente Foundation. OPM has included additional organ/tissue transplant recommendations from an external review by The National Cancer Institute of the National Institutes of Health.

Plans must provide coverage for the organ/tissue transplants that appear in Table 1. Each plan must specify whether or not it will provide coverage in 2007 for the organ/tissue transplants that appear on Tables 2 and 3 and return this information with its 2007 benefit proposal. Plans may cover additional organ/tissue transplants that do not appear on the tables. If your Plan covers an organ/tissue transplant that does not appear on the tables, please submit the additional transplant(s) and include the specific diagnosis and disease staging in the 2007 benefit proposal.

Plans must update their 2007 brochures fully to reflect specific organ/tissue transplant coverage including the corresponding diagnosis and disease staging. Plans must base their organ/tissue transplant coverage decisions strictly on the list of covered diagnoses and disease staging as it appears in their 2007 brochure. Plans may continue to fully review solid organ transplants for medical necessity. However, plans must limit their medical necessity review for all other transplants to the diagnosis and/or the staging of the illness (e.g., acute, chronic, etc.). If plans deny coverage, they must be strictly a

contractual denial (e.g., diagnosis and staging of the illness is not listed as covered). Plans may not deny organ/tissue transplants as experimental/investigational. The experimental/investigational exclusion will no longer apply to organ/tissue transplants under the FEHB Program and OPM will not uphold the denial

Prescription Drugs

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

Plans must clearly show their prescription drug benefits in terms of copays /coinsurance and payment levels in the 2007 brochure. For example, Level I is a $10 copayment for generic drugs (others may apply); Level II is a $30 copayment for brand drugs (others may apply); and Level III is 50% of the Plan allowance ($35 minimum) for non-formulary brand drugs (others may apply).

Benefit Changes

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

- Describe the benefit change completely. Show the proposed brochure language, including the "How we change for 2007" section in "plain language" that is, in the active voice and from the enrollee's perspective. Show clearly how the change will affect members. Be sure to show the complete range of the change. For instance, if you are proposing to add an inpatient hospital copay, indicate whether this change will also apply to inpatient hospitalizations under the emergency benefit. If there are two or more changes to the same benefit, please show each change clearly.

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

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

Benefit Clarifications

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

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

- Explain the reason for the benefit clarification.

Preparing Your 2007 Brochure

We have implemented a new brochure process for 2007. The new process is a web-based application that uses database software. Plans may begin using the web-based application on July 7, 2006. The *2007 FEHB Brochure Handbook* will be ready by the first week of May. Plans can download the *Handbook* from the file manager at http://www.opm.gov/filemanager. To receive a user name and password, please contact Angelo Cueto at (202) 606-1184 or angelo.cueto@opm.gov. If you are proposing a new option, please send Section 5 Benefits information along with your proposal.

We will send plans a *2007 FEHB Program Brochure Application User Manual* by mid-June and we will hold two web-based trainings for all plans following the *Manual's* release. In August, we will issue a second version of the *2007 FEHB Brochure Handbook* with final language changes and shipping labels. We will send each plan a brochure quantity form when the OPM contract specialist approves the brochure for printing.

Before plans begin using the web-based application, OPM will enter all general brochure (boiler plate) language. Plans are responsible for entering all data into Section 5 Benefits and updating all plan specific information by October 15, 2006. Also, until the new process is complete, plans will continue to use the FEHB Word brochure template to develop their plan brochure during negotiations and to print their brochures. Once plans have received approval to print their brochures, plans can cut and paste Section 5 Benefits and any other plan specific information into the web-based form. The new fillable form will be used to automatically generate a 508 compliant PDF. We will post the 508 compliant PDF on the FEHB website.

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

High Deductible Health Plans (HDHP)

The U.S. Department of The Treasury (Treasury) requires that an HDHP have an annual deductible of at least $1,100 for Self Only coverage and annual out-of-pocket expenses (deductibles, co-payments, etc.) that do not exceed $5,250. For Self and Family coverage, an HDHP must have an annual deductible of at least $2,200 and annual out-of-pocket expenses that do not exceed $10,500. **Both the deductible minimum and out-of-pocket expense maximums are indexed for inflation**. Because we anticipate an increase in the minimum annual deductible amount, we will not accept proposals with deductibles less than $1,100 for Self Only and $2,200 for Self and Family coverage.

An HDHP may not provide benefits for any year until the member meets the annual deductible. However, a plan may offer first-dollar coverage for preventive care (or have only a small deductible) and still be defined as an HDHP. Additional Treasury guidance may be found at: http:/www.treas.gov/offices/public-affairs/hsa/. The following guidance applies for health plans proposing to offer an HDHP for 2007. We have provided a checklist of this guidance in Attachments II - VI. Please include this information in your proposal.

- HDHPs must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). These requirements are included in Attachment III.

- HDHP proposals should reflect that these choices will be open to everyone within the defined service area eligible to enroll in the FEHB Program.

- We will evaluate HDHP proposals in accordance with OPM premium rating guidelines.

- Your HDHP proposal must include an HSA and an HRA component. The HRA component is available only to enrollees who are ineligible for an HSA. Attachment IV includes a list of components.

- Proposals should reflect costs only, including the amounts the Plan will deposit/credit to the enrollee's HSA or HRA. Attachment V includes a list of costs.

- Proposals should clearly describe the health benefits that the Plan offers, including deductibles, co-payments, and any other out-of-pocket amounts for in-network and out-of-network services, if applicable.

- Please complete Attachment VI.

- Proposals should include a description of catastrophic limitations and how they apply to self-only and family enrollments (i.e., is there any "imbedded" one-person catastrophic limit).

- You should describe your HDHP provider network and provide evidence that there will be sufficient access to in-network primary, specialty and tertiary providers.

- Proposals should include a description of the HDHP health education program components that the Plan offers.

- Proposals should also include sophisticated health education and consumer education components that leverage state-of-the-art information technology and provide for transparency in cost and quality.

- Proposals should include a complete description of the geographic service area.

- Proposals should include a certification that the state in which your health plan operates has no mandates requiring first dollar coverage for any medical benefit that would keep the plan from qualifying as an HDHP.

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

Tax-favored HSAs are available to those who have an HDHP. However, HSAs are not open to people enrolled in Medicare or another medical benefit health plan (with certain exceptions as provided in Treasury's guidance). Therefore, health plans that are proposing HDHP/HSAs should also propose an HRA of equivalent value for enrollees who are ineligible for an HSA. The HRA could be used for medical expenses, including Medicare premiums. The following guidance applies for health plans proposing to offer an HDHP and HSA/HRA for 2007:

- HSAs must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and applicable Treasury Guidance.

- HRAs must meet applicable Treasury requirements.

- Fiduciary institutions for HSAs and HRAs must be banks or other non-bank trustees or custodians approved by Treasury. However, the health plan may choose to manage the HRA component in-house.

- Health plan proposals should clearly state how they intend to meet Treasury requirements pertaining to HSA and HRA fiduciary responsibilities.

- Health plan proposals must include assurances that its fiduciary is financially stable. At a minimum, a major financial rating service must rate the trustee/custodian in one of its two highest categories for the most recent available rating period. All proposals should provide evidence of this minimum rating level.

- Plans that offer HDHP and HSA/HRA proposals must describe, in detail, the flow of funds from receipt to disbursement to the designated fiduciary.

- Plans must also provide a detailed description from the fiduciary demonstrating how the HSAs and HRAs financial mechanisms and transactions will be established and monitored, including earnings for individual accounts.

- HDHP and HSA/HRA proposals that include the use of debit or credit cards should describe in detail how the Plan will manage and monitor them, including accounting for earned interest. Transaction fees associated with debit cards may not be charged to FEHB Program funds.

- Proposals should state how fees and ancillary charges to individual accounts will be paid for.

NOTE: Final brochure language is <u>not</u> required with your May 31 submission.
OPM will work with you to jointly develop brochure language.

Carrier Contracting Officials

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

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

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

for _____(Plan)

Enrollment code (s):_____

Typed name Title Signature Date

_____

_____

_____

_____

_____

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

_____
(Typed name and title)

_____ _____
(Phone number) (FAX Number)

_____
(Email address)

Attachment I: 2007 Organ/Tissue Transplants and Diagnoses:

Table 1: Required Coverage

I. Solid Organ Transplants: Subject to Medical Necessity	Reference
Cornea	Call Letter 92-09
Heart	Call Letter 92-09
Heart-lung	Call Letter 92-09
Kidney	Call Letter 92-09
Liver	Call Letter 92-09
Pancreas	Call Letter 92-09
Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas	Carrier Letter 2001-18
Lung: Single/double	Carrier Letter 91-08
II. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. Plan's Denial is Limited to the Staging of the Diagnosis (e.g. acute, chronic).	
Allogeneic transplants for:	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Advanced Hodgkin's lymphoma	
Advanced non-Hodgkin's lymphoma	
Chronic myelogenous leukemia	
Severe combined immunodeficiency	
Severe or very severe aplastic anemia	
Autologous transplants for:	
Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Call Letter 96-08B
Advanced Hodgkin's lymphoma	Call Letter 96-08B
Advanced neuroblastoma	Call Letter 96-08B
Advanced non-Hodgkin's lymphoma	Call Letter 96-08B
Autologous tandem transplants for:	
Recurrent germ cell tumors (including testicular cancer)	Call Letter 2002-14
III. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity	
Allogeneic transplants for:	
Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)	
Autologous transplants for:	
Multiple myeloma	Carrier Letter 94-23, Call Letter 96-08B
Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Carrier Letter 94-23, Call Letter 96-08B
IV. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity.	

May Be Limited to Clinical Trials.	
Autologous transplants for:	
Breast cancer	Carrier Letter 94-23 Call Letter 96-08B
Epithelial ovarian cancer	Carrier Letter 94-23 Call Letter 96-08B

Table 2: Recommended For Coverage. Transplants Under Clinical Trials

Blood or Marrow Stem Cell Transplants	Does your plan cover this transplant for 2007?	
	Yes	**No**
Allogeneic transplants for:		
Chronic lymphocytic leukemia		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Nonmyeloablative allogeneic transplants for:		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Advanced forms of myelodysplastic syndromes		
Advanced Hodgkin's lymphoma		
Advanced non-Hodgkin's lymphoma		
Breast cancer		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Colon cancer		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Myeloproliferative disorders		
Non-small cell lung cancer		
Ovarian cancer		
Prostate cancer		
Renal cell carcinoma		
Sarcomas		
Autologous transplants for:		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Autologous transplants for the following autoimmune diseases:		
Multiple sclerosis		
Systemic lupus erythematosus		
Systemic sclerosis		

Table 3: Recommended For Coverage

Solid Organ Transplants	Does your plan cover this transplant for 2007? Yes?	No?
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis		
Lung: Lobar		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced forms of myelodysplastic syndromes		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		
Myeloproliferative disorders		
Sickle cell anemia		
Thalassemia major (homozygous beta-thalassemia)		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Amyloidosis		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		

Attachment II: 2006 Call Letter and Technical Guidance Checklist

High Deductible Health Plan Proposal Information	
1. High Deductible Health Plans (HDHP) must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). (See Attachment III)	
2. HDHP proposals should reflect that these choices will be open to everyone within the defined service area eligible to enroll in the FEHB Program.	
3. HDHP proposals will be evaluated in accordance with OPM premium rating guidelines.	
4. HDHP proposals must include both Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA) components. The HRA component is available only to enrollees who are ineligible for an HSA. (See Attachment IV)	
5. Proposals should reflect costs only, including the amounts to be deposited/credited to the enrollee's HSA or HRA. (See Attachment V)	
6. Proposals should specify the annual dollar amounts of the deposits from premium for the enrollee's HSA or HRA. (See Attachment V)	
7. Proposals should clearly describe the health benefits to be offered, including deductibles, co-payments, and any other out-of-pocket amounts for in-network and out-of-network services, if applicable. (See Attachment VI)	

Attachment II: 2006 Call Letter and Technical Guidance Checklist (Cont.)

High Deductible Health Plan Proposal Information	
8. Proposals should include a description of all preventive care benefits and any applicable out-of-pocket amounts. (See Attachment V)	
9. Proposals should include a description of catastrophic limitations and how they will be administered for Self Only and for Self and Family enrollments (i.e., is there any "imbedded" one-person catastrophic limit).	
10. The HDHP provider network to be used should be described and evidence provided that there will be sufficient access to in-network primary, specialty and tertiary providers.	
11. Proposals should include a description of the HDHP health education program components to be offered.	
12. Proposals should also include a description of the consumer education program the health plan intends to provide including appropriate use of HSA/HRA funds for necessary medical expenses.	
13. Proposals should include a complete description of the geographic service area.	
14. Proposals should include a statement that the state in which your health plan operates has no mandates requiring first dollar coverage for any medical benefit that would keep the plan from qualifying as an HDHP.	

Attachment II: 2006 Call Letter and Technical Guidance Checklist (Cont.)

HSA and HRA Proposal Information	
15. Health Savings Accounts (HSA) must meet the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and applicable Internal Revenue Service (IRS) Guidance.	
16. Health Reimbursement Arrangements (HRA) must meet applicable IRS requirements.	
17. Health plan proposals should clearly state how they intend to meet IRS requirements pertaining to HSA and HRA fiduciary responsibilities.	
18. Fiduciary institutions for HSAs and HRAs must be banks or other non-bank trustees or custodians approved by the IRS.	
19. Health plan proposals must include assurances their fiduciary is financially stable. At a minimum, the trustee/custodian must be rated by a major financial rating service in one of its two highest categories for the most recent available rating period. All proposals should provide evidence of this minimum rating level.	
20. Plans that offer HDHP and HSA/HRA proposals must describe, in detail, the flow of funds from receipt to disbursement to the designated fiduciary.	
21. Plans must also provide a detailed description from the fiduciary demonstrating how the HSAs and HRAs financial mechanisms and transactions will be established and monitored, including earnings for individual accounts.	
22. HDHP and HSA/HRA proposals that include the use of debit or credit cards should describe in detail how these would be managed and monitored, including accounting for earned interest.	
23. Proposals should state how fees and ancillary charges to individual accounts will be paid for.	

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

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

Requirement	Plan's Federal HDHP
''(A) IN GENERAL.—The term 'high deductible health plan' means a health plan—	
''(i) which has an annual deductible which is not less than— ''(I) $1,100 for self only coverage, and	
''(II) twice the dollar amount in subclause (I) for family coverage, and	
''(ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—	
''(I) $5,250 for self-only coverage, and	
''(II) twice the dollar amount in subclause (I) for family coverage.	
''(B) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B). ''(1) ELIGIBLE INDIVIDUAL.— ''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if— ''(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and ''(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan— ''(I) which is not a high deductible health plan, and ''(II) which provides coverage for any benefit which is covered under the high deductible health plan. **''(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—** **''(i) coverage for any benefit provided by permitted insurance, and** **''(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.**	
''(C) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary).	

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

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

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

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

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

Attachment V: Costs

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

ITEM	HSA	HRA
Premium Pass Through Amount		
Account set-up fee		
• Option 1: Electronic enrollment		
• Option 2: Manual enrollment		
Account maintenance fee		
• Option 1: Paid by account holder		
• Option 2: Paid by employer		
Account Miscellaneous Fees		
Monthly service charge		
Paper statement		
Excess contribution adjustment		
Debit card for new accounts		
Debit card reorder		
Debit card additional card order		
Tax statement copy		
Check transactions		
Debit card transactions		

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

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

	Member Pays	
	Plan Provider	**Non-Plan Provider**
1ST DOLLAR BENEFITS (not subject to the annual deductible)		* Plus any difference between our payment and the actual charges
PREVENTIVE AND SCREENING SERVICES		
Immunizations		
Well Child Immunizations		
TB Skin Test		
Bone Density Screening		
Pap Test		
Well Woman Exam		
Glucose Screening		
Chlamydia Infection Screening		
Colorectal Screening (FOBT, colonoscopy and Sigmoidoscopy)		
Mammography – Screening		
Well Child Care Physician Office Visits (through age)		
Well Child Care Laboratory Tests		
HEALTH ASSESSMENT AND DISEASE MANAGEMENT SERVICES		
COVERED SERVICES		
PHYSICIAN SERVICES		
Physician Office Visits		
Physician Home Visits		
Physician Hospital Visits		
Physician Skilled Nursing Facility Visits		
ER Visits (Physician Charge)		

	Member Pays	
	Plan Provider	**Non-Plan Provider**
Urgent care	• Primary Care Physician: • Specialist:	
Consultation Visits (inpatient)		
BEHAVIORAL HEALTH PHYSICIAN SERVICES		
Mental Health Physician Visits		
Substance Abuse Physician Visits		
DIAGNOSTIC TESTS, LABORATORY AND RADIOLOGY		
Diagnostic Tests (Pre-surgical, X-rays)		
Evaluation for Hearing Aids		
Allergy Testing and Treatment Materials		
Laboratory and Pathology		
Radiology		
MATERNITY AND NEWBORN CARE		
Maternity Care		
Newborn Care		
Circumcision		
SURGICAL SERVICES		
Anesthesia		
Assistant Surgeon		
Surgery		
Treatment of Morbid Obesity		
ORGAN TRANSPLANT SERVICES (Transplants must receive prior authorization unless otherwise noted)		
Corneal Transplants (no pre-auth)		
Kidney Transplants (no pre-auth)		
Simultaneous Small Bowel/Multivisceral Transplant		
Small Bowel Transplant		
Organ Donor Services		
Transplant Evaluation		
	Contracted Provider	**Non-Contracted Provider**
Bone Marrow Transplants		
Heart and Lung Transplants		
Heart Transplants		
Liver Transplant		
Lung Transplants		
Simultaneous Kidney/Pancreas Transplant		
EMERGENCY FACILITY SERVICES		
Ambulance (Ground)		
Ambulance (Air) .		
Emergency Service		
FACILITY SERVICES		
Ambulatory Surgical Center		
Birthing Center		
Hospital • Based on semi-private room rate • Intermediate care, ICU, CCU		

	Member Pays	
	Plan Provider	**Non-Plan Provider**
Observation Care		
Skilled Nursing Facility (___days per year)		
CANCER TREATMENT		
Chemotherapy		
Radiation Therapy		
HOME SERVICES		
Home Health Care		
Hospice		
APPLIANCES, EQUIPMENT AND SUPPLIES		
Durable Medical Equipment, Orthotics and Prosthetics		
Hearing Aids		
REHABILITATIVE SERVICES		
Physical Therapy and Occupational Therapy		
Speech Therapy		
OTHER MEDICAL SERVICES		
Blood and Blood Products		
Dialysis and Supplies		
Inhalation Therapy		
Medical Foods		
PRESCRIPTION DRUGS		
Home IV Therapy		
Human Growth Hormone Therapy		
Injectable Drugs (physician administered)		
Prescription Drugs	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Level I Level II Level III	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Not a benefit
Insulin	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Level I Level II Level III	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Not a benefit

	Member Pays	
	Plan Provider	**Non-Plan Provider**
Diabetic Supplies	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Level I Level II Level III	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Not a benefit
Spacers	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)**	**Retail Pharmacy: (30 day supply)** Level I Level II Level III **Mail Order: (90 day supply)** Not a Benefit
Oral Contraceptives	**Retail Pharmacy: (30 day supply)** Regular Plan benefits **Mail Order: (90 day supply)** Regular Mail Order Benefits	**Retail Pharmacy: (30 day supply)** Regular Plan benefits **Mail Order: (90 day supply)** Not a Benefit
Contraceptive Diaphragms	**Retail Pharmacy and Mail Order**	**Retail Pharmacy**
Treatment of Erectile Dysfunction due to organic cause		
FAMILY PLANNING, FERTILITY AND INFERTILITY SERVICES		
Contraceptive Implants		
Contraceptive IUD		
Diagnosis of Infertility		
In Vitro Fertilization		
Artificial Insemination		
Tubal ligation		
Vasectomy		

Attachment VII: Checklist

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

Topic	***Included in Proposal***
▪ Health Care Costs and Quality Transparency Initiatives	_____
▪ Health Information Technology Initiatives	_____
▪ Enhanced Prescription Drug Management Initiatives	_____
▪ Preventive Care Initiatives	_____
▪ Organ / Tissues Transplants Checklists	_____
▪ High Deductible Health Plan	_____

Please return this checklist with your CY 2007 benefit and rate proposal