Health Alliance HMO

www.healthalliance.org

Customer Service 1-800-851-3379

Health Alliance

2022

A Health Maintenance Organization Standard Option Plan

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See Page 9 for details. This plan is accredited. See Page 13.

IMPORTANT
- Rates: Back Cover
- Changes for 2022: Page 15
- Summary of Benefits: Page 84

Serving: Central, East Central, North Central, Southern and Western Illinois; Western Indiana; and Central and Eastern Iowa

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See Page 15 for requirements.

Enrollment codes for these plans:
K84 Standard Option- Self Only
K86 Standard Option-Self Plus One
K85 Standard Option- Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-168

Important Notice from Health Alliance Medical Plans, Inc.

About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Health Alliance HMO prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, (TTY: 800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

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Introduction

This brochure describes the benefits of Health Alliance HMO under contract (CS1980) between Health Alliance Medical Plans, Inc., on behalf of itself and Health Alliance Midwest, Inc., its wholly owned subsidiary, and the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-800-851-3379 or through our website at www.healthalliance.org. The address for the Health Alliance Medical Plans, Inc. administrative offices is:

Health Alliance HMO
3310 Fields Drive South
Champaign, IL 61822

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or 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, 2022, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2022, see Changes for 2022. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member, "we" means Health Alliance HMO.
- 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.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits 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 employs you or from which you retired.

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except to your healthcare providers, authorized health benefits 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 explanation of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- 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 1-800-851-3379 and explain the situation.

-If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE

1-877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

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);
  - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26). A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- 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 (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include; falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly by your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

The Health Alliance HMO complies with all applicable Federal civil rights laws,including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW Suite 3400-S
Washington, D.C. 20415-3610

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex .
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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 or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup/aspx. The Joint Commission's Speak Up™ patient safety program.

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.

- www.ahrq.org/patients-consumers. 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.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.

- 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.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood or hospital-acquired conditions such as certain infections, severe bedsores and fractures; and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

FEHB Facts

Coverage Information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you 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
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, disability leave, pensions, etc. you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

- **Types of coverage available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee, and one or more eligible family members. Family members include your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self Plus One or 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 Plus One or 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 Plus One or 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 are married.

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your carrier to obtain a Certificate of Creditable Coverage (COCC) or to add a dependent when there is already family Coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a newborn if you currently have a Self Only plan.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **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 Plus One or Self and Family coverage in the 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

  The benefits in this brochure are effective 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 processed according to the 2022 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2021 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.

  If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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.

  Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

  You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

  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 provide health coverage for you. However, you may be eligible for your own FEHB coverage under either 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 additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, Tribal employment or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **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 or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us,, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace coverage in your state. For assistance in finding coverage, please contact us at 1-800-851-3379 or visit our website at www.healthalliance.org

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Health Alliance holds the following accreditation: commendable rating from NCQA. To learn more about this plan's accreditation please visit the following website: National Committee for Quality Assurance (www.ncqa.org)

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. You can also view our provider directory at our website www.healthalliance.org.

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 pay only the copayments and coinsurance 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.

General features of our Standard Option

The standard option offers the flexibility of lower premiums by offering a deductible. There is first dollar coverage (the deductible does not apply) for the most frequently utilized services such as office visits, prescriptions and wellness care.

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 cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Your rights and responsibilities

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.

Health Alliance is a unique managed care organization because physicians own it. Health Alliance Medical Plans, Inc., is the corporate successor to CarleCare, Inc., a not-for-profit health maintenance organization founded by one of the largest multi-specialty group practices in the nation – Carle Clinic Association, P.C., in Urbana, Illinois. CarleCare HMO enrolled its first member in March 1980 and, five years later, became a federally qualified HMO. In 1989, CarleCare was reorganized as a for-profit domestic insurance company owned by Carle Clinic and renamed Health Alliance Medical Plans. As such, Health Alliance can underwrite and administer a full range of managed care products.

Today, Health Alliance is the largest managed care organization based in downstate Illinois, covering most of Central and East Central Illinois, as well as numerous counties in Southern, North Central and Western Illinois and central and Eastern Iowa. The corporate office is located in Champaign, Illinois.

Health Alliance provides convenient access to health care with a large network of quality providers. Physicians and specialists as well as clinics, hospitals, pharmacies and other providers were selected to be part of the Health Alliance provider network because of their reputation for excellence.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Health Alliance Medical Plans at www.healthalliance.org to obtain your Notice of Privacy Practices. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 1-800-851-3379, or write to Health Alliance Medical Plans Inc., 3310 Fields South Drive, Champaign, IL 61822. You may also visit our website at www.healthalliance.org.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website Health Alliance Medical Plans Inc., at www.healthalliance.org. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. A service area is a geographic region consisting of one or more counties that we are authorized to do business in. The county in which you live or work determines your service area and, subsequently, your provider network. When you enroll in the Plan, you will be required to select a Primary Care Physician in your service area. This physician will coordinate all of your medical care.

Should you require specialty or ancillary care, your Primary Care Physician will refer you to a provider in your service area. It is your responsibility to make sure your Primary Care Physician refers you to Plan physicians. Please refer to your provider directory or contact us at 1-800-851-3379. You can also view your provider directory at www.healthalliance.org. If you require care that is not available within your service area, your physician will request an out-of-network referral from a Plan medical director. The Plan will notify the referring physician and you in writing of the decision. To assure coverage, please be sure the out-of-network service has been approved prior to seeking services. Our service area is listed below.

Our service area includes the following counties:

In Illinois: Adams, Alexander, Bond, Boone, Brown, Bureau, Calhoun, Carroll, Cass, Champaign, Christian, Clark, Clay, Clinton, Coles, Crawford, Cumberland, DeKalb, DeWitt, Douglas, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Greene, Grundy, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, Johnson, Kankakee, Kane, Kendall, Knox, LaSalle, Lawrence, Lee, Livingston, Logan, Macon, Macoupin, Madison, Marion, Marshall, Mason, Massac, McDonough, McLean, Menard,, Mercer, Monroe, Montgomery, Morgan, Moultrie, Ogle, Peoria, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Rock Island; Saline, Sangamon, Schyuler, Scott, Shelby, Stark, St. Clair, Stephenson, Tazewell, Union, Vermilion, Wabash, Warren, Washington, Wayne, White, Whiteside, Will, Williamson, Winnebago and Woodford ***In Indiana:*** Fountain, Vermillion and Warren ***In Iowa:*** Benton, Blackhawk, Boone, Bremer, Butler, Calhoun, Carroll, Cedar, Clinton, Dallas, Delaware, Fayette, Greene, Grundy, Guthrie, Hamilton, Hardin, Humboldt, Jasper, Johnson, Jones, Keokuk, Lee, Linn, Louisa, Madison, Marshall, Muscatine, Polk, Poweshiek, Sac, Scott, Story, Tama, Warren, Washington, Webster and Wright:

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 healthcare services out of our service area unless the services have prior plan 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 (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. 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. Changes for 2022

Do not rely only on these change descriptions; this Section 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

- Effective in 2022, premium rates are the same for Non-Postal and Postal employees.

Changes to this Plan

- Your share of the premium rate will increase for Self only, Self Plus One, and Self and Family. See 2022 Rate Information for Health Alliance HMO.

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 letter (for annuitants), or your electronic enrollment system (such as 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 1-800-851-3379 or write to us at Health Alliance, 3310 Fields South Drive, Champaign, IL 61822. You may also request replacement cards through our website at www.healthalliance.org.

Where you get covered care

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

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in-network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan Providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website at www.healthalliance.org.

This plan recognizes that transsexual, transgender, and gender-nonconforming members require healthcare delivered by healthcare providers experienced in transgender health. While gender reassignment surgeons (benefit details found in Section f(b)) and hormone therapy providers (benefit details found in Section 5(f)) play important roles in preventive care, you should see a primary care provider familiar with your overall healthcare needs. Benefits described in this brochure are available to all members meeting medical necessity guidelines.

- **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 at www.healthalliance.org.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a Primary Care Physician. This decision is important since your Primary Care Physician provides or arranges for most of your health care.

- **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

- **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. However, you may receive optometric care for routine eye exams and females may see a Woman's Principal Health Care Provider without a referral. You are responsible for making sure your Primary Care Physician refers you to an in-network specialist. Please refer to your provider directory or you can view our provider directory on our website at www.healthalliance.org. Here are some other things you should know about specialty care:

Here are some 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 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 create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If they decide 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.

If you have a chronic and 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 program 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 specialists 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.

- **Primary care**

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

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

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 1-800-851-3379. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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;

- 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 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 cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under Other services. You must get prior approval for certain services.

- **Other services**

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.

We call this review and approval process "preauthorization". Your physician must obtain preauthorization before sending you to a provider outside your service area or to a non-Plan provider. Some of the services requiring prior authorization are listed below (a complete listing of services requiring prior authorization can be found at www.healthalliance.org:

- Ambulance (non-urgent air and non-urgent ground)
- Bariatric surgery
- Breast reconstruction surgeries
- Breast implant surgeries
- Gynecomastia surgery
- Reduction mammoplasty, female
- Cardiac imaging and procedures (echo, echo stress, cardiac rhythm implantable devices, myocardial perfusion imaging, nuclear medicine, diagnostic heart catheterization)
- Chiropractic and massage therapy
- Clinical trials, phase I, II, III and IV
- Durable Medical Equipment
- Experimental and investigational services
- Gender reassignment procedures
- Genetic testing (including molecular diagnostics)
- Imaging
- CT, CTA, MRI, MRA, PET, 3D
- Obstetrical and diagnostic ultrasound
- Infertility (all diagnostic tests, medications, treatments, etc.)
- Inpatient rehabilitative services
- Interventional pain management
- Joint surgery—select
- Private duty nursing
- Radiation therapy, including but not limited to:
  - Proton beam therapy
  - Stereotactic radiosurgery

- Rehabilitative therapies
  - Occupational therapy
  - Physical therapy
  - Speech therapy
- Skilled nursing facility
- Sleep diagnostics, evaluations and supplies
- Transplant services

- **Inpatient hospital admission**

Precertification is the process by which- prior to your inpatient hospital admission- we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you or your representative, must call us at 1-800-851-3379 before admission or services requiring prior authorization are rendered. Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital that number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgement of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

	You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-800-851-3379. You may also call OPM's FEHB 2 at 1-202-606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-800-851-3379. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim)
• **Concurrent care claims**	A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect. If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we received the claim.
The Federal Flexible Spending Account Program – *FSAFEDS*	**HealthCare FSA (HCFSA)** – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26). FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
• **Emergency inpatient admission**	If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
• **Maternity care**	You do not need to preauthorize your vaginal or cesarean section delivery at a Plan provider. Your Plan Primary Care Physician or specialist will make necessary hospital arrangements and supervise your care.
• **If your treatment needs to be extended**	If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we received the claim.
What happens when you do not follow the preauthorization rules when using non-network facilities	Health Alliance will not cover services rendered by a non-plan provider, except for emergency services, unless your Primary Care Physician refers you and you receive preauthorization from Health Alliance.
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.
If you disagree with our pre-service claim decision	If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

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

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Cost For Covered Services

This is what you will pay out-of-pocket for covered care.

Cost-Sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your Primary Care Physician, you pay a copayment of $30 per office visit.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. The calendar year deductible is $750 per person for Self Only or Self Plus One enrollments. Under a Self and Family enrollment, benefits are payable for any individual when the $750 per person deductible is satisfied, or the deductible is considered satisfied and benefits are payable for all family members when the combined expenses applied to the calendar year deductible for all family members reach $1500. Note: If you change plans during Open Season, you do not have to start a new deductible under your prior 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. If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.
Coinsurance	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: You pay 25% of our allowance for durable medical equipment.
Difference between our Plan allowance and the bill	You should also see section Important Notice About Surprise billing - Know Your rights below that describes your protections against surprise billing under the No Surprises Act.
Your catastrophic protection out-of-pocket maximum	After your copayments and coinsurance totals $7,350 for Self Only or $7,350 per person for Self Plus One, or $14,700 per Self and Family enrollment for the Standard Option, in any calendar year, you do not have to pay any more for covered services. Be sure to keep accurate records of your deductibles, copayments and coinsurance since you are responsible for informing us when you reach the maximum.
Carryover	If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing - Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protection against "surprise billing" and "balance billing" under certain circumstances. A surprise bill is an unexpected bill you receive from a nonparticipating health care provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care - when you have little or no say in the facility or provider from whom you receive care. They can also happen when you receive non-emergency services at participating facilities, but you receive some care from nonparticipating providers.

Balance billing happens when you receive a bill from a nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from unexpected bills.

In addition, your health plan adopts and complies with the surprise billing laws of Illinois, Iowa and Indiana.

For specific information on surprise billing, the rights and protections you have, and your responsibilities, go to www.healthalliance.org or contact the health plan at 800-851-3379.

Section 5. Standard Option Benefits

Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections.

Standard Option Benefits Overview

This Plan offers the Standard Option benefit. The benefit package is described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard Option Section 5 is divided into subsections. Please read Important things you should keep in mind at the beginning of the subsections. 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 the Standard Option benefits, contact us at 1-800-851-3379 or visit our website at www.healthalliance.org.

The calendar year deductible is $750 per person ($750 per person for Self Plus One, or $1,500 per Self and Family) for the Standard Option. The calendar year deductible applies towards all services except preventative services and services with a flat copayment. The out of pocket maximum is $7,350 for Self Only and $14,700 for Family enrollment.

The Standard Option Plan benefit features include:

- $30 copayment per office visit to a Primary Care Physician. No deductible.
- $60 copayment per office visit to a Specialist. No deductible applies.
- 25% coinsurance after the deductible is met per inpatient admission
- 25% coinsurance after the deductible is met per outpatient surgical admission.
- $300 copayment per emergency room visit. No deductible.
- $0/$10/$40/$140/$200/50% copayment/coinsurance on Tiers 1, 2, 3, 4, 5 or 6 for a 30-day supply of prescription drugs. No deductible.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should 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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is $750 per person ($750 per person for Self Plus One, or $1,500 per Self and Family) for the Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "Deducible Applies" to show when the calendar year deductible does apply.
- 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.

Benefit Description	You pay
Diagnostic and treatment services	**Standard Option**
Professional services of physicians • In physician's office	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible.
Professional services of physicians • In an urgent care center • Office medical consultation • Second surgical opinion • Advance care planning • At home • Virtual visit	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. Nothing (No deductible) for the first 3 visits per calendar year for any covered Virtual visit; $30 copayment per Virtual visit beginning with the 4th visit (No deductible) (combined with Primary Care Physician, Mental Health/Substance Use Disorder)
Professional services of physicians • During a hospital stay • In a skilled nursing facility	25% coinsurance, deductible applies.
Lab, X-ray and other diagnostic tests	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-ray • Non-routine mammogram • CT/CAT Scan • MRI • Ultrasound • Electrocardiogram and EEG	25% coinsurance, deductible applies.

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	**Standard Option**
• Surveillance test for ovarian cancer	25% coinsurance, deductible applies.
CT Scans/PET Scans/MRI	**Standard Option**
• CT Scans • MRI • PET Scans	25% coinsurance, deductible applies
Preventive care, adult	**Standard Option**
Annual physicals and annual well women visits are covered as wellness visits. Additional visits are subject to the office visit copayments. The following preventive services are covered at the time interval recommended at each of the links below. To access the most up-to-date version of your Wellness brochure, Be Healthy, log into HealthAlliance.org. This brochure includes a detailed listing of services and procedures, and their associated procedure code. To build your personalized list of preventive services go to https://health.gov/myhealthfinder Screenings for asymptomatic members, such as: • Osteoporosis • Cholesterol/lipid once every 5 years age 20 and over • Depression • Diabetes • High blood pressure • Sexually transmitted infection (counseling and screening) • Alcohol and drug misuse • Tuberculosis infections for adults at increased risk • Hepatitis B virus • Colorectal cancer screening including: - At home DNA stool test every 3 years for asymptomatic, average risk adults ages 45-75 - Fecal occult blood test including immunoassay (FIT), 1-3 simultaneous determinations annually for asymptomatic adults at age 45 - Sigmoidoscopy once every five years for adults age 45-75	Nothing.

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Standard Option**
- Colonoscopy once every ten years for adults age 45-75 - CT colonography once every five years for adults age 45-75 when an incomplete colonoscopy is performed first • Ultrasound for Abdominal Aortic Aneurysm for men ages 65-75 who have ever smoked • Lung cancer screening with low-dose computed tomography (LDCT) ages 50-80 with a 20 pack/year, or who quit within the past 15 years. Preauthorization is required . Individual counseling, prevention and reducing health risks • Fall prevention exercise interventions, community-dwelling adults 65 and older at increased risk for falls • Behavioral counseling for skin cancer prevention ages 6 months to 24 years with fair skin	Nothing.
Well woman care; based on current recommendations such as: • Cervical cancer screening (Pap smear) every 3 years ages 21-65 • High Risk Human papillomavirus (HPV) testing age 30 and over • Chlamydia/gonorrhea screening age 24 or younger and older women at increased risk • Clinical breast exams • Screening mammogram, including breast tomosynthesis (3D mammogram) age 35 and over • BRCA counseling and evaluation when personal or family history of breast, ovarian tubal or peritoneal cancer is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes • Breast Cancer Chemoprevention counseling when at increased risk for breast cancer and at low risk for adverse medication effects of risk reducing chemoprevention	Nothing.
Preventive care screenings for pregnant women in addition to preventive care services already listed such as: • Anemia • Preeclampsia	Nothing.

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Standard Option**
• Urinary tract or other infection • Gestational diabetes • Hepatitis B • Sexually transmitted disease • Rh Incompatibility screening	Nothing.
• Annual counseling and screenings for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence • Perinatal depression: counseling and interventions • Obesity screening and counseling • Tobacco use screening and counseling • Healthy diet and physical activity counseling for adults with cardiovascular risk factors	Nothing.
Routine mammogram - covered for women	Nothing.
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. • Human papillomavirus vaccine for Members age 9–26 • Shingles vaccine for Members 50 years of age and older; • Hepatitis A • Influenza vaccine; • MMR(Measles, mumps and rubella); • Meningococcal; • Pneumococcal; • Tetanus, Diphtheria, Pertussis; • Haemophilus influenzae type b; • Inactivated Poliovirus; • Rotavirus; • Varicella;	Nothing.

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Standard Option**
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventative Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-brecommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html **Women's preventive services:** www.healthcare.gov/preventive-care-women/ For additional information: healthfinder.gov/myhealthfinder/default.aspx	Nothing.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges.*
Preventive care, children	**Standard Option**
Well-child visits, examinations, and other preventive services as described in the Bright Futures Guidelines provided by the American Academy of Pediatrics. The following preventive services are covered at the time interval recommended at each of the links below. • Obesity screening and counseling ages 6 and older • Autism screening for children at 18 and 24 months • Behavioral assessments as part of preventive exams • Fluoride Chemoprevention supplement products generic single ingredient only, for children 6 months to 5 years or without fluoride in their water source • Varnish application for children age 0-6 years old is covered • Hearing screening for newborns and children	Nothing.

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**Standard Option**
• Height, Weight and Body Mass Index as part of preventive exams • Hematocrit or Hemoglobin screening • Hemoglobinopathies or sickle cell screening for Newborns • Lead screening age 0-6 years old who are at risk for exposure • Oral health risk assessment • Phenylketonuria (PKU) screening for this genetic disorder in Newborns • Tuberculin testing when at higher risk of tuberculosis • Congenital Hypothyroidism screening for infants ages 0-90 days old • Developmental screening for children under age 3, and surveillance throughout childhood • Vision screening for children Note: A complete list of preventive care services recommended under the U.S. Preventative Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index_html For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance and deductible. Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx	Nothing.

Benefit Description	You pay
Maternity care	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your vaginal or cesarean delivery; see Section 3, Inpatient hospital admission for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal 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 Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	$60 copay nothing thereafter for routine prenatal care. No deductible. Note: You are responsible for 25% coinsurance for inpatient or outpatient facility charges. Please refer to **Section 5(c) Services provided by a hospital or other facility and ambulance services** for information.
Breastfeeding support, supplies and counseling for each birth.	Nothing.
Family planning	**Standard Option**
Contraceptive counseling on an annual basis	Nothing.
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) - Tubal ligation for females - Vasectomies performed as an office procedure for males • Surgically implanted contraceptives	Females pay nothing if done for contraceptive purposes. You pay only your office visit copayment. $30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance per outpatient surgical admission, deductible applies

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	**Standard Option**
• Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives and other prescription pharmacy contraceptives under the prescription drug benefit.	Females pay nothing if done for contraceptive purposes. You pay only your office visit copayment. $30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance per outpatient surgical admission, deductible applies Note: If for males or reasons other than contraceptive or family planning purposes, then you pay the appropriate deductible, copayment (office visit, surgical, durable medical equipment) or coinsurance.
Genetic Testing • Genetic testing and molecular diagnostic testing is covered when determined to be Medically Necessary. Note: Preauthorization and approval is required. Testing that is determined to be experimental or investigational is not covered.	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance other covered services while done in the office, deductible applies 25% coinsurance per outpatient surgical admission, deductible applies
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges.*
Infertility services	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination (AI) • Assisted Reproductive Technologies (ART) • Intravaginal insemination (IVI) • Itracervical insemination (ICI) • Intrauterine insemination (IUI) • In Vitro Fertilization (IVF) • Uterine embryo lavage • Embryo transfer • Gamete intrafallopian tube transfer • Zygote intrafallopian tube transfer • Low tubal ovum transfer Note: Approval of infertility services must follow the Plan medical policy. Note: Infertility services after reversal of Sterilization are covered if there is a successful reversal of Sterilization and if the diagnosis meets the definition of Infertility.	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance per outpatient surgical admission, deductible applies

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**Standard Option**
Note: Fertility drugs, including injectables, specialty prescription drugs and oral fertility drugs, are paid under the prescription drug benefit; see Section 5(f) Prescription Drug Benefits.	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance per outpatient surgical admission, deductible applies
Fertility Preservation Services • This plan covers standard fertility preservation services for members when a medically necessary treatment may directly or indirectly result in impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting the reproductive organs or processes. Note: Preauthorization and Health Alliance approval is required.	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance per outpatient surgical admission, deductible applies
Not covered: • Non-medical co*st of donor sperm* • *Non-medical cost of donor egg*	*All charges.*
Allergy care	**Standard Option**
• Testing and treatment • Allergy injections	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance other covered services while done in the office, deductible applies
Allergy serum	25% coinsurance, deductible applies
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges.*
Treatment therapies	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants. • Respiratory and inhalation therapy • Cardiac rehabilitation following a qualifying event or condition • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) - Children with autism spectrum disorder	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance during a covered inpatient admission, deductible applies IV or oral specialty drugs are covered under the specialty prescription drug benefit.

Benefit Description	You pay
Physical,Occupational and Speech therapies	**Standard Option**
A combined total of 60 visits per condition per calendar year for the outpatient services of each of the following: • Qualified physical therapists • Occupational therapists • Qualified speech therapists Note: We only cover therapy when a provider as listed above: • orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed, Inpatient rehabilitation services are covered under the Extended care benefits/skilled nursing facility benefits/rehabilitation benefits heading of Section 5 (c).	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance during a covered inpatient admission, deductible applies
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Phase III cardiac rehabilitation*	*All charges.*
Hearing services (testing, treatment, and supplies)	**Standard Option**
• External Hearing Aids	All charges over the $750 maximum benefit for hearing aids/ devices every three years.
• Screening and testing services for hearing aids	All charges over the $100 maximum benefit for screening and testing services for a hearing aid every three years.
Not covered: *Hearing services that are not shown as covered*	*All charges.*
Vision services (testing, treatment, and supplies)	**Standard Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions and exams Note: See *Preventive care, children* for eye exams for children.	$60 per vision exam. No deductible.
Not covered:	*All charges.*

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	**Standard Option**
• *Eyeglasses or contact lenses, and contact lens fittings except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	**Standard Option**
• 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	$30 per office visit to a Primary Care Physician $60 per office visit to a Specialist
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	**Standard Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Internal prosthetic devices, such as artificial joints, pacemakers and surgically implanted breast implant following mastectomy. • Custom molded foot orthotics • Lumbosacral supports Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	25% coinsurance, deductible applies
Not covered:	*All charges.*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**Standard Option**
• *Orthopedic and corrective shoes(except for diabetic shoes when medical criteria is met),* arch supports,heel pads, and feel cups • *Corsets, trusses, elastic stockings, support hose and other supportive devices* • *Prosthetic replacements provided less than five years after the last one we covered, unless it is irreparable and the member has properly maintained it.*	*All charges.*
Durable medical equipment (DME)	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors • Insulin pumps • Audible prescription reading devices • Speech generating devices • Lancets Note: Call us at 1-800-851-3379 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	25% coinsurance, deductible applies
Home health services	**Standard Option**
50 home healthcare service visits are covered per calendar year. • Home healthcare ordered by a Plan physician and provided by a registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN) or home health aide • Services include oxygen therapy, intravenous therapy and medications	25% coinsurance, deductible applies
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family*	*All charges.*

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	**Standard Option**
• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative*	*All charges.*
Chiropractic	**Standard Option**
• Manipulation of the spine and extremities is covered if referred by the Primary Care Physician and approved by a medical director. • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy and cold pack application are covered as rehabilitative therapy services and are subject to 60 treatments per condition per calendar year. Hot/cold pack therapy used in conjunction with approved manipulation and mobilization is covered. X-rays and other diagnostic testing are covered under diagnostic and treatment services and must be provided by a Plan provider. Note: Spinal manipulations and mobilizations are covered when long-term significant improvement can be expected from such treatment.	$60 per office visit. No deductible.
Alternative treatments	**Standard Option**
• Acupuncture - a combined total of 15 treatments for the diagnosis of low back pain, neck pain and headaches	$30 per office visit. No deductible.
• Biofeedback - under certain circumstances	$60 per office visit to a Specialist. No deductible.
Not covered: • *Naturopathic services* • *Hypnotherapy*	*All charges.*
Educational classes and programs	**Standard Option**
Coverage is provided for: • Diabetes self management training and education • Childhood Obesity Education	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible.
Tobacco cessation programs, including individual/group/phone counseling, and for physician prescribed over the counter (OTC) and prescription drugs approved by the FDA to treat nicotine dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco cessation dependence.

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**Standard Option**
• Health Alliance offers *Quit4Life,* a telephone-based tobacco cessation program. Interested members may call 1-866-784-8454 to determine their readiness to quit. If they are ready, they may enroll in the program and choose the level of phone support they want from our trained health coaches. Enrollees will receive a free quit kit by mail. In addition, the member's health coach will follow up with the member and the member's physician throughout the year. Members are eligible to enroll in *Quit4Life* twice per 12 month period. • Enrollees may get nicotine replacement therapy (gum, lozenges or patches) or the option prescriptions drugs Zyban®, prescription Chantix® or Bupropion (generic Zyban) for each quit attempt with no copayment. The plan will pay for 30 day supply at a time. These medications must be obtained by prescription.	Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco cessation dependence.
Gender Affirmation Treatment	**Standard Option**
Gender Affirmation treatment is covered when determined to be Medically Necessary. Preauthorization and Health Alliance approval is required for surgical procedures. See section 5(b)	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance during a covered inpatient admission, deductible applies
Enteral-Parenteral Nutrition Products	**Standard Option**
This plan covers enteral-parenteral nutritional products when determined to be Medically Necessary. Note: Preauthorization and Health Alliance approval is required.	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance other covered services while done in the office, deductible applies

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should 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.
- The calendar year deductible is $750 per person ($750 per person for Self Plus One, or $1,500 per Self and Family) for the Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "deductible applies" to show when the calendar year deductible does apply.
- 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 services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES**. Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.

Benefit Description	You pay
Surgical procedures	**Standard Option**
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 (bariatric surgery) if medical criteria determined by the plan are met. See Services requiring our approval. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization for Non-Contraceptive purposes (e.g., tubal ligation) (vasectomy only covered in a physician's office) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done.	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance if you are an inpatient or outpatient in a hospital or at an ambulatory surgical facility, deductible applies

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**Standard Option**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Foot care)*	*All charges.*
Reconstructive surgery	**Standard Option**
• 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 of breasts - 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. • Gender Reassignment Surgery - Gender Affirmation Surgery • Surgical Gender Affirmation treatment requires meeting Gender Affirmation Medical necessity criteria and: • Member is 18 years of age or older, and • Documentation that the member has the capacity to make a fully informed decision and consent to treatment, and	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance if you are an inpatient or outpatient in a hospital or at an ambulatory surgical facility, deductible applies

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**Standard Option**
• Documentation that the member has lived continuously for at least 12 months in the gender role that is consistent with the preferred gender, without periods of time returning to the individual's original gender, and • Member has completed at least 12 months of continuous hormonal sex reassignment therapy unless medically contraindicated (not required before mastectomy in FtM transition), - Surgical procedures covered include: • Female-to-male surgical reassignment-FtM (all procedures require prior authorization submitted by the member's primary care physician and medical director review). Bilateral mastectomy or breast reduction, hormone therapy is not required before mastectomy. Hysterectomy and salpingo-oophorectomy. Vaginectomy (including colpectomy, metoidioplasty with initial phalloplasty, urethroplasty, urethromeatoplasty) • Male-to-female surgical reassignment-MtF (all procedures require prior authorization submitted by the member's primary care physician and medical director review). Orchiectomy Vaginoplasty (including colovaginoplasty, penectomy, labiaplasty, clitoroplasty, vulvoplasty, penile skin inversion, repair of introitus, construction of vagina with graft, coloproctostomy) - Not Covered: • Reversal of previous hormonal and/or surgical Gender Affirmation procedures. • Procedures considered cosmetic • Procedures considered investigational, based upon limited literature evidence for their use for transgender individuals	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance if you are an inpatient or outpatient in a hospital or at an ambulatory surgical facility, deductible applies
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*	*All charges.*

Benefit Description	You pay
Oral and maxillofacial surgery	**Standard Option**
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 • Other surgical procedures that do not involve the teeth or their supporting structures	$30 per office visit to a Primary Care Physician. No deductible. $60 per office visit to a Specialist. No deductible. 25% coinsurance if you are an inpatient or outpatient in a hospital or at an ambulatory surgical facility, deductible applies
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*
Organ/tissue transplants	**Standard Option**
These **solid organ transplants** are covered. These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Lung: single/bilateral/lobar • Kidney • Kidney-pancreas • Liver • Pancreas • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas	25% coinsurance, deductible applies
Blood or marrow stem cell transplants The plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for	25% coinsurance, deductible applies

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPD's) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Hemoglobinopathy - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e. Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Muscopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippos's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed)	25% coinsurance, deductible applies

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
- Amyloidosis - Breast cancer - Childhood rhabdomyosarcoma - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Mantle Cell (Non-Hodgkin's lymphoma) - Medulloblastoma - Multiple myeloma - Myelodysplasia/Mylodysplastic syndromes - Neuroblastoma - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency disease (e.g., Wiskott-Aldrich syndrome) - Pineoblastoma - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors.	25% coinsurance, deductible applies
Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer	25% coinsurance, deductible applies
Mini-transplants performed in a clinical trial setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for	25% coinsurance, deductible applies

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
- Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced myeloproliferative disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic(i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	25% coinsurance, deductible applies
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma (de novo and treated) - AL Amyloidosis	25% coinsurance, deductible applies

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Heath **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy(CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (nonmyeloablative allogeneic transplants or reduced intensity condition (RIC) for - Acute lymphocytic or non-lymphocytic (i. e. myelogenous) leukemia - Myelodysplasia/Myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma	25% coinsurance, deductible applies

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
- Multiple sclerosis - Myeloproliferative disorders (MDD's) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Autologous transplants for - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CSS/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members. • National Transplant Program (NTP)	25% coinsurance, deductible applies
Transportation, lodging and meals for the transplant recipient and a companion for travel to and from a Plan-designated center of excellence is covered. If the patient is a minor, transportation and reasonable and necessary lodging and meal costs for two persons who travel with the minor are included. Expenses for meals and lodging are reimbursed at the per diem rates established by the Internal Revenue Service.	Please contact Health Alliance at 1-800-851-3379 for the current per diem reimbursement rates.
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs*	*All charges.*

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
• *Transplants not listed as covered* • *Experimental organ or tissue transplants*	*All charges.*
Anesthesia	**Standard Option**
Professional services provided in – • Hospital (inpatient)	25% coinsurance, deductible applies
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	25% coinsurance, deductible applies
Professional services provided in - • Office	25% coinsurance, deductible applies

Section 5(c). Services Provided By a Hospital or Other Facility and Ambulance Services

Important things you should 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 and you must be hospitalized in a Plan facility.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "deductible applies" when the calendar year deductible does apply. The calendar year deductible is: $750 per person ($750 per person Self Plus One enrollment, or $1,500 per Self and Family) for the Standard Option.
- 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 in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You pay
Inpatient hospital	**Standard Option**
Room and board, such as • Ward, semiprivate or intensive care accommodations • General nursing care • Meals and special diet. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	25% coinsurance, deductible applies
Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Dressings, splints, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Rehabilitative services	25% coinsurance, deductible applies
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes and schools*	*All charges.*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**Standard Option**
• *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	**Standard Option**
• Operating, recovery and other treatment rooms • Prescribed drugs and medications • 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 • Dressings, casts and sterile tray services • Medical supplies, including oxygen • Anesthetics 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.	25% coinsurance, deductible applies
Not covered: • *Blood and blood derivatives not replaced by the member*	*All charges.*
Extended care benefits/skilled nursing care facility benefits/rehabilitative services	**Standard Option**
Up to 75 days are covered per calendar year. Extended care benefit: Rehabilitative services received in an acute inpatient setting.	25% coinsurance, deductible applies
Not covered: • *Custodial care*	*All charges.*
Hospice care	**Standard Option**
Supportive and palliative care for terminally ill members is covered in the home or hospice facility. Services include inpatient or outpatient care and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately 12 months or less.	25% coinsurance, deductible applies
Not covered:	*All charges.*

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	**Standard Option**
• *Independent nursing, homemaker services*	*All charges.*
End of life care	**Standard Option**
See Hospice care	25% coinsurance, deductible applies
Ambulance	**Standard Option**
Local professional and air ambulance service when medically appropriate	$100 copayment per occurrence for emergency ambulance transportation. No deductible.

Section 5(d). Emergency Services/Accidents

Important things you should 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.
- The calendar year deductible is $750 per person ($750 per person Self Plus One enrollment, or $1,500 per Self and Family) for the Standard Option. The calendar year deductible applies to almost all benefits in this Section. We added "deductible applies" to show when the calendar year deductible does apply.
- 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.

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 the 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: If you are in an emergency situation, call the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or your family member should notify the Plan within 48 hours after care begins unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified in a timely manner.

If you need to be hospitalized, the Plan must be notified within 48 hours after care begins or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-plan facilities and the Plan physicians believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this plan, follow-up care recommended by non-plan providers must be approved by the Plan or provided by Plan physicians.

Emergencies outside our service area: Benefits are available for any medically necessary service that is immediately required due to illness or unforeseen injury.

If you need to be hospitalized, the Plan must be notified within 48 hours after care begins or on the first working day following your admission, unless it is not reasonably possible to notify the Plan within that time. If a Plan physician believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, follow-up care recommended by non-plan providers must be approved by the Plan or provided by Plan physicians.

Benefit Description	You pay
Emergency within our service area	**Standard Option**
• Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: If admitted, the emergency room copayment is waived and you pay the appropriate inpatient hospital admission copayment.	$60 per urgent care visit. No deductible. $300 per emergency room visit. No deductible.
Emergency outside our service area	**Standard Option**
• Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$60 urgent care visit. No deductible. $300 per emergency room visit. No deductible.
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *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*	*All charges.*
Ambulance	**Standard Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	$100 copayment per occurrence for emergency ambulance transportation. No deductible.

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should 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.
- The calendar year deductible is: $750 per person for the Standard Option ($750 per person Self Plus One enrollment, or $1,500 per Self and Family enrollment). The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "deductible applies" to show when the calendar year deductible does apply.
- 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.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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.

Benefit Description	You pay
Professional services	**Standard Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Virtual visit	$30 per office visit. No deductible. Nothing (No deductible) for the first 3 visits per calendar year for any covered Virtual visit; $30 copayment per Virtual visit beginning with the 4th visit (No deductible) (combined with Primary Care Physician, Mental Health/Substance Use Disorder)

Benefit Description	You pay
Diagnostics	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner. • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	25% coinsurance, deductible applies
CT Scan/PET Scan/MRI	**Standard Option**
• Outpatient CT Scans, PET Scans and MRI's provided and billed by a licensed mental health and substance abuse practitioner. • Outpatient CT Scans, PET Scans and MRI's provided and billed by a hospital or other covered facility. • Inpatient CT Scans, PET Scans and MRI's provided and billed by a hospital or other covered facility.	25% coinsurance, deductible applies
Inpatient hospital or other covered facility	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services. • Residential treatment. • Inpatient treatment in a Psychiatric Medical Institution for Children (PMIC) is covered for a child diagnosed with a biologically-based mental illness who meets the Iowa medical assistance program criteria for admission to a PMIC.	25% coinsurance, deductible applies
Outpatient hospital or other covered facility	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility Services in approved treatment programs, such as partial hospitalization, full day hospitalization or facility based intensive outpatient treatment	25% coinsurance, deductible applies

Benefit Description	You pay
Not covered	**Standard Option**
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 obtain a treatment plan and follow all of the following network authorization processes: Except in a medical emergency or when a Primary Care Physician has designated another Plan physician to see patients when they are unavailable, you must contact your Primary Care Physician for a referral before seeing any other Plan physician or obtaining specialty services. Referral to a Plan specialist in your service area is given at the Primary Care Physician's discretion. If specialists or consultants are required beyond those participating in the Plan, a Plan medical director must make the approval. A list of the Plan's mental health/substance abuse providers can be found in the Plan's provider directory for your service area or you may contact the Customer Service Department at 1-800-851-3379 to see which mental health/substance abuse providers participate with the Plan in your service area.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- 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.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified providers with prescriptive authority prescribing within their scope of practice.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy or by mail order. For members who take maintenance medications, you have three choices. **Mail order prescriptions and Retail 90^{Rx} are optional and available only to members who take maintenance medications**.
  - Choice 1: Get a 30-day supply of medications for one copayment at a local retail pharmacy. This is the same benefit available for one-time prescriptions.
  - Choice 2: Get 90 days of maintenance medication through mail order and receive a discount.
  - Choice 3: Get 90 days of maintenance medication at a local retail pharmacy and also receive a discount. You must take a prescription for a 90-day supply to a participating Retail 90^{Rx} pharmacy or have your prescription transferred to a Retail 90^{Rx} pharmacy.
- **We use a formulary.** The Plan has a tiered pharmacy copayment structure for each 30-day supply. To keep your costs as low as possible, we ask that you and your physician select appropriate medications from the list. We have an open formulary. However, the Plan recognizes the value of using FDA-approved generic drugs whenever medically appropriate. For this reason, you will always pay the lowest copayment for generic drugs. If your physician believes a brand-name product is necessary or there is no generic available, your physician may prescribe a brand-name drug from the formulary list. This list of brand-name drugs is a preferred list of drugs that we selected to meet your needs at a lower cost. When a generic drug doesn't’t exist, brand-name drugs that are not on our preferred list require the highest copayment level. To order a prescription drug brochure, call 1-800-851-3379 or you can view our formulary on our website, www.healthalliance.org.
- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referring physician and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. Maintenance medication can be dispensed for up to a 90-day supply through mail order or at a pharmacy participating in Retail 90^{Rx}.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **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 these drugs meet the same standards of quality and strength as brand-name drugs.
- **When you do have to file a claim.** If you have to pay out-of-pocket for a prescription because you do not have your ID Card, please contact our Customer Service Department at 1-800-851-3379 for information on submitting your claim.

Benefit Description	You pay
Covered medications and supplies	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Prescription drugs prescribed by a Plan or referring physician and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply or manufacturer's standard package. • Members who take maintenance medication and choose the options of mail order or Retail 90^{Rx} at a participating pharmacy for a 90-day supply, will pay 2.75 copayments (instead of three copayments) for a 90-day supply. • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin and diabetic supplies including glucagon emergency kits, syringes and needles, oral legend agents for controlling blood sugar, and test strips for glucose monitors. • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction - Must be medically necessary - Member must be 18 years or older - Covered quantity limited to four tablets per 30-day period - Member cannot be on nitrates - No coverage for women • Prescription contraceptives • Drugs to treat gender dysphoria • Hormonal Reassignment therapy - Coverage requires meeting medical necessity criteria for Gender Affirmation treatment, and a primary care physician or endocrinologist's letter describing the medical necessity for hormone therapy to establish eligibility for this benefit initially, then Pharmacy Department prior authorization of the specific hormone(s) requested. - Procedures considered investigational, based upon limited literature evidence for their use for transgender individuals	At a Plan pharmacy per prescription unit or refill: $0 Tier 1 (Preferred generic and Preventive drugs) $10 Tier 2 (Non-Preferred Generic) $40 Tier 3 (Preferred Brand drugs) $140 Tier 4 (Non-Preferred Brand drugs) For members on maintenance medication that choose to use the options of mail order or Retail 90^{Rx}, copayments are based on a 90-day supply. You pay 2.75 copayments for a 90-day supply: $0.00 Tier 1 $27.50 Tier 2 $110.00 Tier 3 $385.00 Tier 4 Note: If there is no generic equivalent available, you will still have to pay the brand-name copayment. Note: If the physician allows substitution and the member prefers a brand-name drug on the formulary instead of the generic (if available), the member pays $10 plus the difference in cost between the generic and the brand-name drug. If the physician does not allow substitutions, the member will pay the brand name copayment.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
• Some prescription drugs require preauthorization from a Plan medical director and certain criteria to be met by the member. The member's physician must contact the Plan to obtain preauthorization. To accord with changes in medical technology, the Plan maintains a list of pharmaceuticals that require preauthorization. The list is available to the member upon request. Failure to obtain preauthorization may result in the dispensing pharmacy requiring personal payment from the member.	At a Plan pharmacy per prescription unit or refill: $0 Tier 1 (Preferred generic and Preventive drugs) $10 Tier 2 (Non-Preferred Generic) $40 Tier 3 (Preferred Brand drugs) $140 Tier 4 (Non-Preferred Brand drugs) For members on maintenance medication that choose to use the options of mail order or Retail 90^{Rx}, copayments are based on a 90-day supply. You pay 2.75 copayments for a 90-day supply: $0.00 Tier 1 $27.50 Tier 2 $110.00 Tier 3 $385.00 Tier 4 Note: If there is no generic equivalent available, you will still have to pay the brand-name copayment. Note: If the physician allows substitution and the member prefers a brand-name drug on the formulary instead of the generic (if available), the member pays $10 plus the difference in cost between the generic and the brand-name drug. If the physician does not allow substitutions, the member will pay the brand name copayment.
Specialty Prescription Drugs Some Specialty Prescription Drugs are covered when provided by a Participating Provider. Coverage is subject to prior written order by your Physician and Preauthorization by a Medical Director. To be consistent with changes in medical technology, Health Alliance will maintain a list of covered Specialty Prescription Drugs and the medical conditions for which they are approved for coverage. Examples of Specialty Prescription Drugs include: Interferons, Erythropoietin and granuloctye colony stimulating factor (G-CSF). Specialty Prescription Drugs must be purchased through Walgreens, either through the mail or local retail store and are limited to a 30-day supply. Coverage can be verified by calling the Customer Services Department at 1-800-851-3379. Tier 5 specialty drugs are the most clinically and cost effective, these are also known as Preferred Specialty Drugs.	$200 copayment for Tier 5 Specialty Prescription Drugs 50% coinsurance for Tier 6 Specialty Prescription Drugs

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
Tier 6 specialty prescription drugs are at a higher cost then Tier 5 and usually have clinically comparable alternatives available at the Tier 5 level. These are also known as Non-Preferred Specialty drugs. Growth hormone therapy (GHT) Note: We will only cover GHT when we preauthorize treatment. Call 1-800-851-3379 for preauthorization. We will ask you to submit information that established the GHT is medically necessary. 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.	$200 copayment for Tier 5 Specialty Prescription Drugs 50% coinsurance for Tier 6 Specialty Prescription Drugs
Prescription Contraceptives Tier 1 prescription contraceptive pills, patches, the ring and the morning after pill will be covered at a preferred pharmacy under the preventative benefit. Tier 2 , Tier 3 and Tier 4 prescription contraceptive pills, patches, ring and morning after pill are covered under the prescription drug benefit. FDA approved over the counter contraceptive products (including but not limited to condoms, sponges, and spermicide) are also covered for women with a prescription at a preferred pharmacy under the preventative benefit. with a $0 copayment. Coverage is limited to one package per month. One type of contraceptive pharmacy product is covered per month. You must have a prescription and coverage is limited to women only.	For Tier 1 you pay Nothing. For Tier 2, Tier 3 and Tier 4 are subject to the Tier 2, Tier 3 or Tier 4 prescription drug copayment For FDA approved over the counter contraceptives you pay nothing.
Not covered • ***Drugs and supplies for cosmetic purposes*** • ***Drugs to enhance athletic performance*** • ***Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies*** • ***Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them*** • ***Non-prescription medications***	All Charges

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
• ***Drugs for which there is a non-prescription equivalent available*** • ***Medical supplies, such as dressings & antiseptics*** *Note: Physician prescribed over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the tobacco cessation benefit.*	All Charges
Preventive medications	**Standard Option**
Medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a healthcare professional and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Pre-natal vitamins for pregnant women • Flouride tablets, solution (not toothpaste, rinses) for children 0-6 Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.	Nothing

Section 5(g). Dental Benefits

Important things you should 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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- The calendar year deductible is $750 per person ($750 per person for Self Plus One, or $1,500 per Self and Family) for the Standard Option. The calendar year deductible applies to all benefits in this Section. We added "deductible applies" to show when the calendar year deductible does apply.
- We cover hospitalization for dental procedures only when a non-dental 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.

Benefit Description	You Pay
Accidental injury benefit	**Standard Option**
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.	25% coinsurance, deductible applies
Dental benefit	**Standard Option**
We have no other dental benefits.	*All charges.*

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Services for deaf and hearing impaired	TTY 711 or 1-800-526-0844 (Illinois Relay)
Reciprocity benefit	The Plan offers a reciprocity program for family members living temporarily away from home in an area serviced by the Plan. Under this program, family members living away can receive coverage for medically necessary routine care. For additional information on this program, or to enroll a family member, call the Customer Service Department at 1-800-851-3379.
Health and Wellness Programs	See the Health Alliance website for information on Health and Wellness programs available to you as a member at https://www.healthalliance.org/health-and-wellness

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, please contact the Plan at 1-800-851-3379 or visit our website at www.healthalliance.org.

Medicare prepaid plan enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. Annuitants and former spouses with FEHB coverage and Medicare Part B may elect to suspend their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join the Medicare prepaid plan, but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits, and if so, what you will have to pay. Contact your retirement system for information on suspending your FEHB enrollment and changing to a Medicare prepaid plan. Contact the Plan at 1-800-965-4022 for information on the Medicare prepaid plan and the cost of that enrollment.

LifeBalance Program

This Plan offers the LifeBalance Program to you at no cost. Please visit our website at www.healthalliance.org/federal for more information on thousands of discount options on your favorite activities.

Section 6. General Exclusions – Services, Drugs and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*)
- Services, drugs or supplies you receive while you are not enrolled in this Plan
- Services, drugs or supplies 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 where the fetus has a condition incompatible with life outside the uterus
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Services, drugs, or supplies you receive without charge while in active military service
- Services or supplies we are prohibited from covering under the law.

Section 7. Filing a Claim for Covered Services

This section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, 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 deductible, copayment, or coinsurance.

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 and hospital benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS 1500, Health Insurance Claim Form. Your facility will file on the UB 04 form. For claims questions and assistance, contact us at 1-800-851-3379, or at our website at www.healthalliance.org.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider 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 payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Health Alliance Medical Plans, Inc.

3310 Fields South Drive

Champaign, IL 61822

Prescription drugs

All Plan pharmacies will file your claim electronically with you only being responsible for your copayment. However, if for any reason you had to pay for your prescriptions out of pocket, please call the Customer Service Department at 1-800-851-3379 for information on submitting your claim.

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.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. if matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance) , and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 if you disagree with our pre-service claim decision, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claims. To make your request, please contact our Customer Service Department by writing to 3310 Fields South Drive, Champaign, Illinois, 61822 or calling 1-800-851-3379.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision..

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

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: Health Alliance Medical Plans, 3310 Fields South Drive, Champaign, IL 61822; 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 of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you , free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claims decision. We will provide you with this information sufficiently in advance of the date we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information.

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.

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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, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 2, 1900 E. Street, NW, Washington, DC 20415-3620.

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 benefit (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.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

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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 file a lawsuit, 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 file a lawsuit 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 serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-800-851-3379. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 2 at 1-202-606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the our website at www.healthalliance.org.

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

When we are the secondary payor, the primary payor will pay on the claim first, up to its plan limit. If the claim is paid in full by the primary payor, we will not pay anything. If the claim is not paid in fully by the primary payor, we will pay the claim based on the remaining charge, up to our allowance. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare 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 TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) 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 similar agency pays its maximum benefits for your treatment, we will cover your care.

- **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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under out coverage.

If you have received benefits or benefits payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receives payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment receives by settlement, judgement, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to use out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgement, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 1-877-888-3337 (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded, conducted under an investigational new drug application reviewed by the Food and Drug Administration,; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan covers some of these costs, providing the Plan determines the services are medically necessary. For more specific information see *Organ/tissue transplants* in Section 5(b). We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.

- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2018) or at www.medicare.gov.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) 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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-851-3379 or see our website at www.healthalliance.org.

We waive some costs if the Original Medicare Plan is your primary payor – If you are enrolled in the Standard Option plan, we will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other healthcare professionals. If you are enrolled in Medicare Part B, you may not have to pay all deductibles, copayments or coinsurance.

Please review the following as it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description: Deductible
You pay without Medicare: Standard Option: $750
You pay with Medicare Part B: Standard Option: $0

Benefit Description: Out-of-Pocket Maximum
You pay without Medicare: Standard Option: $7,350 for Self only or $7,350 per person for Self Plus One or $14,700 for Self and Family
You pay with Medicare Part B: Standard Option: Standard Option: $0

Benefit Description: Primary Care Physician
You pay without Medicare: Standard Option: Standard Option: $30 copayment
You pay with Medicare Part B: Standard Option: Standard Option: $0

Benefit Description: Specialist
You pay without Medicare: Standard Option: $60 copayment
You pay with Medicare Part B: Standard Option: Standard Option: $0

Benefit Description: Inpatient Hospital
You pay without Medicare: Standard Option: Standard Option: 25% coinsurance, Deductible Applies.
You pay with Medicare Part B: Standard Option: Standard Option: $0

Benefit Description: Outpatient Hospital
You pay without Medicare: Standard Option: Standard Option: 25% coinsurance, Deductible Applies.
You pay with Medicare Part B: Standard Option: Standard Option: $0

Benefit Description: RX
You pay without Medicare: Standard Option: Standard Option: $10/$40/$140/$200/$300/50%
You pay with Medicare Part B: Standard Option: Standard Option: Standard Option: $10/$40/$140/$200/$300/50%

Benefit Description: RX-Mail Order (90 day supply)
You pay without Medicare: Standard Option: 2.75x retail copay
You pay with Medicare Part B: Standard Option: Standard Option: 2.75x retail copay

You can find more information about how our plan coordinates benefits with Medicare by calling the Customer Service Department at 1-800-851-3379.

- **Tell us about your Medicare Coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: You may enroll in one of our Medicare Advantage plans and also remain enrolled in our FEHB plan. In this case, we do waive some cost sharing for your FEHB coverage.

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

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
5) 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	✓	
6) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

Section 10. Definitions of Terms We Use in This Brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical Trials Cost Categories	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application. • Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a Clinical Trial or is receiving standard therapy • Extra care costs - costs related to taking part in a Clinical Trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care • Research costs - costs related to conducting the Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes These costs are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	The percentage of our negotiated fee that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.
Copayment	A fixed amount of money you pay to the provider, facility, pharmacy, etc. when you receive certain services.
Cost-sharing	The general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial Care	Custodial care means services designed to help beneficiaries meet the needs of daily living whether they are disabled or not. These services include help in: a) walking or getting in and out of bed; b) personal care such as bathing, dressing, eating or preparing special diets; and/or c) taking medication that the beneficiary would normally be able to take without help. Custodial care that lasts 90 days or more is sometimes known as long-term care.
Experimental or investigational service	The Plan considers factors which it determines to be most relevant under the circumstances, such as published reports and articles in the authoritative medical, scientific and peer review literature or written protocols used by the treating facility or being used by another facility studying essentially the same drug, device or medical treatment. This Plan also considers federal and other government agency approval as essential to the treatment of an injury or illness by, but not limited to, the following: American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, the Food and Drug Administration or the National Institutes of Health.
Group health coverage	Any group arrangement that provides a member with hospital, medical, surgical or dental benefits and that consists of employer-sponsored group insurance, association-sponsored group prepayment coverage, coverage under labor-management trusteed plans, employer organization plans or employee benefit organizations.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medical necessity	A service or supply that is required to identify or treat a condition and is:

- Appropriate and necessary for, and consistent with, the symptom or diagnosis and treatment or distinct improvement of an illness or injury.
- Adequate and essential for the evaluation or treatment of a disease, condition or illness.
- Can reasonably be expected to improve the member's condition or level of functioning.
- Conforms with standards of good medical practice, uniformly recognized and professionally endorsed by the general medical community at the time it is provided.
- Not mainly for the convenience of the member, a physician or other provider.
- The most appropriate medical service, supply or level of care that can safely be provided. When applied to inpatient care, it further means that your medical symptoms or condition require that the services cannot be safely provided to you as an outpatient.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance based on reasonable and customary charge. Plan providers accept the Plan allowance as payment in full.

You should also see Important Notice About Surprise Billing - Know Your Rights in Section 4 that describes your protections against surprise billings under the No Surprises Act.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval or a referral and (2) where failure to obtain precertification, prior approval or a referral results in a reduction of benefits.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Us/We

Us and We refer to Health Alliance Medical Plans.

You

You refers to the enrollee and each covered family member.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care of treatment that is the subject of the claim.

Urgent care claims usually involve pre-service claims and not post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-851-3379. You may also prove that your claim is an urgent care claims by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Index

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

Notes

Summary of Benefits for the Standard Option of the Health Alliance HMO Plan - 2022

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at https://www.healthalliance.org/federal
- 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.
- Below, an asterisk (*) means the item is subject to the $750 calendar year deductible.

Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copayment: $30 primary care: $60 specialist. No deductible. 25% coinsurance for lab, X-ray or other diagnostic tests, deductible applies	27
Service provided by a hospital: Inpatient	*25% coinsurance, deductible applies	51
Service provided by a hospital: Outpatient	*25% coinsurance, deductible applies	52
Emergency benefits: In-area	$60 urgent care visit/$300 hospital ER. No deductible.	55
Emergency benefits: Out-of-area	$60 urgent care visit/$300 hospital ER. No deductible.	55
Mental health and substance use disorder treatment:	Regular cost-sharing	56
Prescription drugs: Retail pharmacy	$0/$10/$40/$140 No deductible.	60
Prescription drugs: Mail order	$27.50/$110/$385 No deductible.	60
Dental care:	No benefit	64
Vision care:	$30 copayment for primary care physician office visit. No deductible. $60 copayment for specialist office visit. No deductible.	36
Special features:	• Flexible benefits option • Services for deaf and hearing impaired • Reciprocity benefits	65
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $7,350/Self Only or $14,700/ Family enrollment per year	22

2022 Rate Information for Health Alliance HMO

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare

To review premium rates for all FEHB health plan options please go to **www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.**

Premiums for Tribal Employees are shown under the Monthly Premium Rate column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Standard Option Self Only	K84	$243.72	$81.24	$528.06	$176.02
Standard Option Self Plus One	K86	$521.12	$173.70	$1,129.08	$376.36
Standard Option Self and Family	K85	$564.89	$188.29	$1,223.92	$407.97