FEHB Program Carrier Letter
All Fee-for-Service Carriers

U.S. Office of Personnel Management
Insurance Services Program

Letter No. 2010-11(c) **Date: May 5, 2010**

Fee-for-service [8] Experience-rated HMO [8] Community-rated [7]

Subject: 2011 Technical Guidance and Instructions for Preparing Proposals for Fee-For-Service Carriers

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2010, through December 31, 2010. Please refer to our annual *Call Letter* (Carrier letter 2010-06) dated April 7, 2010 for *policy guidance*. Benefit policies from prior years remain in effect.

Your complete proposal for benefit changes and clarifications is due no later than **May 31, 2010.** Please send a copy of your proposal to your contract specialist on a CD-ROM or other electronic means in addition to a hard copy. Your proposal should include the corresponding language that describes your proposed changes for the brochure. Your OPM contract specialist will negotiate your 2011 benefits with you and finalize the negotiations in a close-out letter.

Please send an electronic version of your fully revised 2011 brochure to your contract specialist within five business days following the receipt of the close-out letter **or** by the date set by your contract specialist.

As a reminder, each year we assess carriers' overall performance. We consider your efforts to submit benefit and rate proposals timely and the accurate and timely production and distribution of brochures, as major factors in your plan's overall performance. Enclosed for your convenience is a checklist (Attachment IX) with the information you need to provide. Please return the completed checklist along with your benefit and rate proposals.

As part of your proposal, please include your carrier's proposed layout for "Going Green." Attachment VIII includes additional information on this initiative.

We look forward to working closely with you on these essential activities to ensure a successful Open Season again this year.

Sincerely,

Kathleen M. McGettigan
Acting Associate Director
for Retirement and Benefits

2011 FEHB Proposal Instructions

Preparing Your Benefit Proposal

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

- A plain language description of each proposed change (in worksheet format) and the revised language for your 2011 brochure;
- A plain language description of each proposed clarification (in worksheet format) and the revised language for your 2011 brochure; and
- A signed contracting official's form.

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

Eliminate Cost Sharing - As stated in our Call Letter, benefits for coverage of all recommended in-network preventive care, immunizations, and screenings will be provided with no cost sharing. A list of recommended preventive services (including immunizations) by the Advisory Committee on Immunizations Practices (ACIP) in conjunction with the American Academy of Pediatrics (AAP), U.S. Preventive Services Task Force (USPSTF), and Health Resources and Services Administration (HRSA) is included in Attachment IV, Tables 1 – 3.

Smoking Cessation – OPM will follow-up as soon as possible on implementation clarification for the 2011 contract year.

Donor Testing Services - We are enhancing benefits related to donor testing services for bone marrow and stem cell transplants. We encourage proposals that include testing for up to four potential bone marrow transplant donors per year from individuals unrelated to the patient, in addition to testing of family members.

Medicare Coordination Programs - We are again encouraging proposals from plans for Medicare coordination programs for annuitants within existing plan options. We are seeking pilot programs that coordinate FEHB benefits with Medicare Part B.

Assistive Technologies - We again encourage you to review your benefits on assistive technologies, including hearing aids, speech generating devices, and prescription drug readers. For those plans which offer these benefits with dollar limitations, we are encouraging proposals to increase those dollar amounts.

Childhood Obesity - We again encourage you to provide us with proposals for health promotion programs to educate enrollees about childhood obesity.

Healthy Lifestyles - We expect you to enhance your efforts in promoting consumer awareness about healthy lifestyles and avoidance of the onset of chronic conditions and encourage you to provide

proposals to expand incentives related to healthy lifestyles.

Affordability – We will work closely with you to find ways to manage costs and utilization effectively.

Value-Based Benefit Design – Please establish how your complete benefit package is value-based.

Catastrophic Limitations - Please address any changes to the catastrophic limitations.

Health Care Cost and Quality Transparency Initiatives – We continue to encourage you to expand your health care cost and quality transparency initiatives to broaden the use of health information technology (HIT) and to educate consumers on the value of HIT and transparency.

Preventable Medical Errors - We encourage you to review your coverage guidelines with respect to preventable medical errors and to revise your policies as long as you have arrangements in place to protect your members from balance billing.

Organ/Tissue Transplants
We have updated the guidance on organ/tissue transplants which we provided in last year's technical guidance.
When a carrier determines that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at the time that determination is made. Carriers are not obligated to wait for the next contract year before they begin providing such benefits. We have updated the following tables in Attachment VI:

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

Mental Health Parity - The Department of Health and Human Services, Department of Labor, and Department of Treasury released interim final regulations for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Under these rules, health plans cannot have separate deductible and out-of-pocket maximum requirements that are applicable only with respect to mental health or substance use disorders. This means plans must accrue member expenses toward the same deductibles and out-of-pocket maximums for both medical and surgical benefits and mental health and substance use disorder benefits.

These regulations require parity between medical/surgical and mental health/substance use disorder benefits with respect to financial requirements (copayment, coinsurance, deductibles, and out-of-pocket maximums) or treatment limitations (visit or treatment limit) in the following six classifications: (1) inpatient, in-network, (2) inpatient, out-of-network, (3) outpatient, in-network, (4) outpatient, out-of-network, (5) emergency care, and (6) prescription drug benefits. A financial requirement or treatment limitation must be compared only to a financial requirement or treatment limitation of the same type (copayments, coinsurance, etc.). For instance, copayments are compared only to other copayments; copayments cannot be compared to coinsurance and vice versa.

In addition, the regulations state a health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant (level of type of financial requirement applied to more than one half) financial requirement

or treatment limitation of that type that is applied to substantially all (at least two-thirds) medical/surgical benefits in the same classification. In other words, if copayments are identified as the financial requirement applied to substantially all medical/surgical benefits (measured by plan costs) in that classification and there are multiple levels of copayments, the level that applies to more than one half would be considered the "predominant" financial requirement for that classification. Similarly, if a single level applies to at least two-thirds of medical/surgical benefits in a classification, then that level is considered the predominant level that applies to mental health/substance use benefits in that classification. Example: Plan A copayments apply to at least two-thirds of inpatient/in-network classification and there are two levels of copayments ($20 & $30); however, the $30 copayment applies to more than one-half of the benefits in that classification, in this case the $30 copayment would be the predominant level.

The regulations prohibit discrimination in the application of non-quantitative treatment limitations, such as medical management standards, prescription drug formulary design, determinations of usual, reasonable and customary amounts, step therapy, and requiring benefits be subjected to a condition such as completing a course of treatment. Any elements used in non-quantitative treatment limitations for mental health benefits must be comparable to those used for medical and surgical benefits. The regulations allow variations to this rule to the extent that recognized clinically appropriate standards of care permit a difference; therefore, concurrent review of mental health care can be required even if the same is not required for medical surgical care.

For further guidance refer to carrier Letter No. 2008-17 and Letter No. 2009-08 as well as the Interim Final Rules implementing the Act: http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf

Prescription Drugs

All plans must meet creditable coverage requirements. The prescription drug benefit must be at least as good as the standard Medicare Part D Benefit.

Prescription drug benefits for Fee-For-Service (FFS) plans listed in the *2011 Guide to Federal Benefits* will be consistent with the prescription drug payment levels listed for Health Maintenance Organizations (HMO). Prescription drug payment levels will be listed as Level I, Level II, and Level III. These levels will show your current co-pays/coinsurance for generic, brand name and non-formulary, as well as other specific drug categories that may apply to your plan. If your plan has multiple (more than three payment levels, i.e., generic, brand name and non-formulary) for prescription drug coverage, please work with your OPM contract specialist to ensure that we accurately reflect your coverage in the *2011 Guide to Federal Benefits.*

Plans must clearly show their prescription drug benefits in terms of co-pays/coinsurance and payment levels in the 2011 brochure. For example, Level I is a $10 copayment for generic drugs (others may apply); Level II is a $30 co-payment for brand drugs (others may apply); and Level III is 50% of the plan allowance ($35 minimum) for non-formulary brand drugs (others may apply).

Durable Medical Equipment. Please indicate which items you cover by completing the checklist in Attachment VII.

Benefit Changes

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

- Describe the benefit change completely. Show the proposed brochure language, including the "How we change for 2011" section in "plain language" that is, in the active voice and from the enrollee's perspective. Show clearly how the change will affect members. Be sure to show the complete range of the change. For instance, if you are proposing to add an in-patient hospital co-pay, indicate whether this change will also apply to in-patient hospitalizations under the emergency benefit**. If there are two or more changes to the same benefit, please show each change clearly.**

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

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

Benefit Clarifications

Clarifications are not benefit changes. Please use Attachment III as a template for submitting benefit clarifications**.** Clarifications help enrollees understand how a benefit is covered**.** For each clarification:

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

- Explain the reason for the benefit clarification.

Preparing Your 2011 Brochure

We will continue to use the brochure process we implemented last year. This process is a web application that uses database software. The web application will generate a 508 compliant PDF.

The *2011 FEHB Brochure Handbook* will be ready by June 1. Plans can download the *Handbook* from the file manager at www.opm.gov/filemanager. To receive a user name and password, please contact Angelo Cueto at (202) 606-1184 or angelo.cueto@opm.gov. If you are proposing a new option, please send Section 5 Benefits information along with your proposal. In August, we will also send you a brochure quantity form and other related Open Season instructions.

We will provide updates to the FEHB Brochure Templates between June 1and August 11, 2010. We will not issue a second version of the *2011 FEHB Brochure Handbook*; however, we will post the revised FEHB Handbook pages and a revised Brochure Template to the File Manager. We should have all language and shipping labels finalized no later then August 11, 2010. We will send each plan a brochure quantity form when the OPM contract specialist approves the brochure for printing.

The *2011 Brochure Creation Tool (BCT) User Manual* will be available July 1. Also in July, we will provide in-house training to refresh plans on the use of the BCT. There will be 10 separate training sessions held at OPM. We will send an email via the FEHB Carriers listserv as to the dates and times of these trainings. Please send any comments or questions pertaining to the Brochure Creation Tool to Angelo Cueto at angelo.cueto@opm.gov.

Plans are responsible for entering all data into Section 5 Benefits and updating all plan specific information in the brochure tool by September 17, 2010. Plans will be unable to make any changes on September 18, 2009, as we will lock-down the tool to enable contract specialists to review PDF versions of plan brochures. If changes need to be made, we will unlock plan brochures on a case-by-case basis.

Attachment I: Carrier Contracting Officials

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

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

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

for _____(Plan).

Enrollment code (s):_____

Typed name Title Signature Date

_____

_____

_____

_____

_____

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

_____
(Typed name and title)

_____ _____
(Phone number) (FAX number)

_____
(Email address)

Attachment II

[Insert Health Plan Name]
Benefit Change Worksheet #1
[Insert Subsection Name]

Please complete a separate worksheet for each proposed benefit change. Please refer to Benefit Changes on page 5 to complete the worksheet.

Benefit Change Description

Applicable options:

High Option	☐	CDHP	☐
Standard Option	☐	HDHP	☐
Basic	☐		

Item	Narrative Description
Current Benefit	
Proposed Benefit	
Proposed Brochure Language	
Reason	
Cost Impact / Actuarial Value	

Additional Questions:

I. Actuarial Value:
   (a) Is the change an increase or decrease in existing benefit package?
   (b) Is an increase, describe whether any other benefit is off-set by your proposal

II. What is the cost impact of this change as a bi-weekly amount for Self Only and Self and Family rate?
   (a) If there is no impact or if the proposal involves a cost trade-off with another benefit change, show the trade-off or a cost of zero, as appropriate.

Attachment #III

[Insert Health Plan Name]
Benefit Clarification Worksheet #1
[Insert Subsection Name]

Please refer to Benefit Clarifications on page 5 to complete the worksheet.

Please Note: If the benefit clarification equates to a benefit change, you must indicate it as a benefit change in the Benefit Change Worksheet.

Benefit Clarification Description

Applicable options:

High Option	☐	CDHP	☐
Standard Option	☐	HDHP	☐
Basic	☐		

Current Benefit Language	Proposed Benefit Change	Reason For Benefit Clarification

Attachment IV: U.S. Preventive Services Task Force (USPSTF)

Table 1: U.S. Preventive Services Task Force (USPSTF)

USPSTF	Current FEHB Preventive Services	Adults		Special Populations	
		Men	Women	Pregnant Women	Children
Abdominal Aortic Aneurysm, Screening	Abdominal Aortic Aneurysm, Screening	X			
Alcohol Misuse Screening and Behavioral Counseling Interventions	Alcohol Misuse Screening and Behavioral Counseling Interventions	X	X	X	
Aspirin for the Prevention of Cardiovascular Disease	Aspirin for the Prevention of Cardiovascular Disease	X	X		
Asymptomatic Bacteriuria in Adults, Screening	Asymptomatic Bacteriuria in Adults, Screening			X	
Breast Cancer, Screening	Breast Cancer, Screening		X		
Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing	Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing		X		
Breastfeeding, Primary Care Interventions to Promote	Breastfeeding, Primary Care Interventions to Promote		X	X	
Cervical Cancer, Screening	Cervical Cancer, Screening		X		
Chlamydial Infection, Screening	Chlamydial Infection, Screening		X	X	
Colorectal Cancer, Screening	Colorectal Cancer, Screening	X	X		
Congenital Hypothyroidism, Screening					X

Dental Caries in Preschool Children, Prevention	Dental Caries in Preschool Children, Prevention				X
Depression (Adults), Screening	Depression (Adults), Screening	X	X		
Diabetes Mellitus in Adults, Screening for Type 2	Diabetes Mellitus in Adults, Screening for Type 2	X	X		
Diet, Behavioral Counseling in Primary Care to Promote a Healthy Diet	Diet, Behavioral Counseling in Primary Care to Promote a Healthy Diet	X	X		
Gonorrhea, Screening	Gonorrhea, Screening		X	X	
Gonorrhea, Prophylactic Medication	Gonorrhea, Prophylactic Medication				X
Hearing Loss in Newborns, Screening					X
Hepatitis B Virus Infection, Screening	Hepatitis B Virus Infection, Screening			X	
High Blood Pressure, Screening	High Blood Pressure, Screening	X	X		
HIV, Screening	HIV, Screening	X	X	X	X
Iron Deficiency Anemia, Prevention	Iron Deficiency Anemia, Prevention				X
Iron Deficiency Anemia, Screening	Iron Deficiency Anemia, Screening			X	
Lipid Disorders, Screening	Lipid Disorders, Screening	X	X		
Major Depressive Disorder in Children and Adolescents, Screening					X
Obesity in Adults, Screening	Obesity in Adults, Screening	X	X		
Osteoporosis in Postmenopausal Women, Screening	Osteoporosis in Postmenopausal Women, Screening		X		
Phenylketonuria, Screening					X
Rh (D) Incompatibility, Screening	Rh (D) Incompatibility, Screening			X	

Sexually Transmitted Infections. Counseling		X	X		X
Sickle Cell Disease, Screening	Sickle Cell Disease, Screening				X
Syphilis Infection, Screening	Syphilis Infection, Screening	X	X	X	
Tobacco Use and Tobacco-Caused Disease, Counseling to Prevent	Tobacco Use and Tobacco-Caused Disease, Counseling to Prevent	X	X	X	
Visual Impairment in Children Younger than Age 5 Years, Screening	Visual Impairment in Children Younger than Age 5 Years, Screening				X

Table 2: Advisory Committee on Immunizations Practices (ACIP)

ACIP Recommended Vaccine Immunizations (Ages 0 through 6 years)	ACIP Recommended Vaccine Immunizations (Ages 7 through 18 years)	ACIP Recommended Adult Immunizations	FEHB Immunizations
Diphtheria, Tetanus, Pertussis	Diphtheria, Tetanus, Pertussis	Hepatitis A	**X**
Haemophilus Influenzae, Type B	Hepatitis A	Hepatitis B	**X**
Hepatitis A	Hepatitis B	Human Papillomavirus	**X**
Hepatitis B	Human Papillomavirus	Influenza	**X**
Inactivated Poliovirus	Inactivated Poliovirus	Measles, Mumps, Rubella	**X**
Influenza	Influenza	Meningococcal	**X**
Measles, Mumps, Rubella	Measles, Mumps, Rubella	Pneumococcal	**X**
Meningococcal	Meningococcal	Tetanus, Diphtheria, Pertussis	**X**
Pneumococcal	Pneumococcal	Varicella	**X**
Rotavirus	Rotavirus	Zoster	**X**
Varicella	Varicella		**X**

Table 3: Health Resources and Services Administration (HRSA)

HRSA Recommendations for Women	HRSA Recommendations for Infants, Children, and Adolescents	Current FEHB Preventive Services
Cholesterol Screening		**X**
Mammograms		**X**
Pap Smears		**X**
	Influenza	**X**
	Hepatitis B	**X**
	Human Papillomavirus	**X**

Attachment V 2011 Organ/Tissue Transplants and Diagnoses:

Table 1: Required Coverage

I. Solid Organ Transplants: Subject to Medical Necessity	Reference
Cornea	Call Letter 92-09
Heart	Call Letter 92-09
Heart-lung	Call Letter 92-09
Kidney	Call Letter 92-09
Liver	Call Letter 92-09
Pancreas	Call Letter 92-09
Intestinal transplants (small intestine with the liver) or small intestine with multiple organs such as the liver, stomach, and pancreas	Carrier Letter 2001-18
Lung: Single/bilateral/lobar	Carrier Letter 91-08
II. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. Plan's Denial is Limited to the cytogenetics, subtype or staging of the diagnosis (e.g. acute, chronic) as appropriate for the diagnosis.	
Allogeneic transplants for:	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Advanced Hodgkin's lymphoma – relapsed	
Advanced non-Hodgkin's lymphoma - relapsed	
Acute myeloid leukemia	
Advanced Myeloproliferative Disorders (MPDs)	
Amyloidosis	
Chronic lymphocytic leukemia/small lymphocytic leukemia (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	Call Letter 96-08B
Advanced Hodgkin's lymphoma – relapsed	Call Letter 96-08B
Advanced non-Hodgkin's lymphoma - relapsed	Call Letter 96-08B
Amyloidosis	
Neuroblastoma	Call Letter 96-08B

III. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity	
Allogeneic transplants for:	
Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)	
Autologous transplants for:	
Multiple myeloma	Carrier Letter 94-23, Call Letter 96-08B
Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Carrier Letter 94-23, Call Letter 96-08B
IV. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials.	
Autologous transplants for:	
Breast cancer	Carrier Letter 94-23 Call Letter 96-08B
Epithelial ovarian cancer	Carrier Letter 94-23 Call Letter 96-08B
V. Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for member over 60 years of age with a diagnosis listed under Section II): Subject to Medical Necessity	
VI. Tandem transplants: Subject to medical necessity	
Autologous tandem transplants for:	
AL Amyloidosis	
Multiple myeloma (de novo and treated)	
Recurrent germ cell tumors (including testicular cancer)	Call Letter 2002-14

Table 2: Recommended For Coverage. Transplants Under Clinical Trials

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/investigational to being consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2011?	
Blood or Marrow Stem Cell Transplants	**Yes**	**No**
Allogeneic transplants for:		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Non-myeloablative allogeneic transplants for:		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Advanced Hodgkin's lymphoma		
Advanced non-Hodgkin's lymphoma		
Breast cancer		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Colon cancer		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple Myeloma		
Multiple Sclerosis		
Myeloproliferative Disorders		
Myelodysplasia/Myelodysplastic Syndromes		
Non-small cell lung cancer		
Ovarian cancer		
Prostate cancer		
Renal cell carcinoma		
Sarcomas		
Sickle Cell disease		
Autologous transplants for:		
Chronic myelogenous leukemia		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Small cell lung cancer		
Autologous transplants for the following autoimmune diseases:		
Multiple sclerosis		
Systemic lupus erythematosus		

Systemic sclerosis		
Sclerodema		
Scleroderma-SSc (severe, progressive)		

Table 3: Recommended For Coverage

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/investigational to being consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2011?	
Solid Organ Transplants	**Yes**	**No**
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		
Myeloproliferative disorders		
Sickle cell anemia		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom's macroglobulinemia		

Attachment VI: Durable Medical Equipment

Plan Name: _____

Plan Code(s): _____

Please indicate which items you cover and describe the type of coverage you provide.

Item	Yes	No
•Hearing Aids Description:		
•Prescription Drug Readers Description:		
•Scooters Description:		
•Speech Generating Devices Description:		
•Story Boards Description:		
•Talkers Description:		

Attachment VII: Going Green Initiative

We encourage plans to "go green" where possible. Examples of "going green" are as follows:

- **Delivering Plan Brochures -** Please refer to Carrier Letter 2006-17 and provide us with a plan of action detailing how you will distribute brochures electronically.
- **Explanation of Benefits electronically (EOB)**
- **Using summary EOBs**
- **Distributing health plan newsletters**

Please provide us with how your plan will "go green" for the items indicated above as well as any other areas your plan has undertaken. Please include a cost benefit analysis for the items your plan has addressed.

Attachment VIII: Checklist

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

Topic	Included in Proposal
1. Eliminate Cost Sharing for all recommended in-network preventive care, immunizations, and screenings	
2. Smoking Cessation - OPM will follow-up as soon as possible on implementation clarification for the 2011 contract year.	
3. Donor Testing Services - Enhanced benefits related to donor testing services for bone marrow and stem cell transplants that include testing for up to four potential bone marrow transplant donors per year from individuals unrelated to the patient, in addition to testing of family members.	
4. Medicare Coordination Programs for annuitants within existing plan options, and pilot programs that coordinate FEHB benefits with Medicare Part B, if applicable.	
5. Assistive Technologies – Increased dollar amounts on assisted technologies such as hearing aids, speech generating devices, and prescription drug readers, if applicable.	
6. Childhood obesity proposal for health promotion programs, if applicable.	
7. Healthy lifestyles proposal to expand consumer awareness about healthy lifestyles and avoidance of the onset of chronic conditions and proposal to expand incentives related to healthy lifestyles, if applicable.	
8. Value-Based Benefit Design – Establish how your benefit package is value based.	
9. Changes to your catastrophic limit(s), if applicable.	
10. Revised policies regarding preventable medical errors to protect members from balanced billing.	
11. Completed Organ/Tissue Transplants Tables.	
12. Completed Durable Medical Equipment Checklist.	
13. Benefit Change Worksheets for each proposed benefit change (include answers to the value based benefits questions for each benefit change).	
14. Benefit Clarification Worksheet for each proposed benefit clarification.	

15. “Going Green” initiative.	

Please return this checklist with your CY 2011 benefit and rate proposal