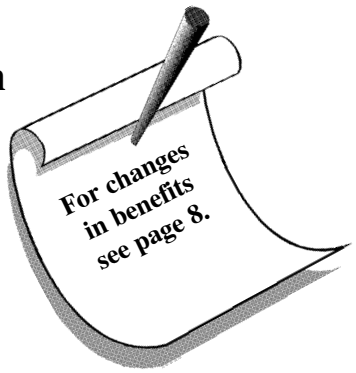
HealthPartners®

HealthPartners Primary Clinic Plan

http://www.healthpartners.com

2002

A Health Maintenance Organization



Serving: Minneapolis-St. Paul-St. Cloud; South Central Minnesota; West Central Wisconsin

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.

This plan has been awarded a "Commendable" accreditation for it's HMO, point-of-service and Medicare products from the National Committee for Quality Assurance (NCQA). This is granted to health plans that deliver high quality care and service and whose systems for consumer protection and quality improvement exceed NCQA's rigorous requirements. See the 2002 Guide for more information on NCQA.

Enrollment codes for this Plan:

HQ1 Self Only
HQ2 Self and Family

Authorized for distribution by the:

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

FEHB
Federal Employees
Health Benefits Program

RI 73-584

Table of Contents

Introduction

HealthPartners, Inc.
8100 34th Avenue South
Minneapolis, Minnesota 55440

This brochure describes the benefits of HealthPartners Primary Clinic Plan under our contract (CS 2649) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

Terms of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means HealthPartners Primary Clinic Plan.

- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.

- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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

Inspector General Advisory

Stop health care fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 952/883-5000 and explain the situation.
- If we do not resolve the issue, call or write

  THE HEALTH CARE FRAUD HOTLINE

  202/418-3300

  The United States Office of Personnel Management

  Office of the Inspector General Fraud Hotline

  1900 E Street, NW, Room 6400

  Washington, DC 20415

Penalties for Fraud

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

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

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

Who provides my health care?

We are a mixed model prepayment plan which allows members to receive health services from individual doctors who practice out of their own offices and through 600 medical clinics and 137 contracting hospitals throughout the Twin Cities and surrounding areas. Our medical providers include more than 2,000 primary care doctors and over 2,600 community specialists to whom patients are referred. Members may choose any medical center in the plan network to receive primary care services. Each covered person in a family may select a different medical center.

Your Rights

OPM requires all FEHB Plans to 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.

HealthPartners, Inc. is a Minnesota nonprofit corporation under Articles of Incorporation dated December 28, 1983, and is operated under the Minnesota Nonprofit Corporation Act, Minnesota Statues Chapter 317A. HealthPartners was formed through the affiliation of Group Health, Inc. and MedCenters Health Plan in 1992. Group Health, Inc. (a 501(c) (3) corporation) has been in existence as a nonprofit corporation since 1957. MedCenters Health Plan was founded in 1972, and is no longer in existence.

HealthPartners is Minnesota's only consumer-guided health plan. Our Board of Directors is composed of consumer-elected members.

HealthPartners is a licensed HMO in the State of Minnesota. Group Health, Inc. is a federally qualified HMO, and received that qualification in 1974.

Information on the following topics is available by calling HealthPartners Member Services:

- Plan preauthorization and utilization review procedures
- Use of clinic protocols, practice guidelines and utilization review standards
- Special disease management programs and programs for persons with disabilities
- Prescription drug formulary and procedures for considering requests of patient-specific waivers
- Qualifications of reviewers at the initial decision and reconsideration under the FEHB disputed claims process

Member Services representatives are available from 7:30 a.m. until 6:00 p.m., Monday through Friday.

If you want more information about us, call 952/883-5000 or 1-800-883-2177 or write to HealthPartners, P.O. Box 1309, Minneapolis, MN 55440-1309. You may also contact us by fax at 952/883-5666 or visit our website at www.healthpartners.com.

Service Area

To enroll in this Plan, you must live or work in our Service Area. This is where our providers practice. Our service area is:

The following counties in Minnesota: Anoka, Benton, Carver, Chisago, Dakota, Dodge, Goodhue, Hennepin, Houston, Isanti, LeSueur, McLeod, Meeker, Morrison, Ramsey, Rice, Scott, Sherburne, Stearns, Steele, Washington, Winona, and Wright.

The following partial counties in Minnesota: Olmsted, Fillmore, Wabasha, and Mille Lacs **

The following counties in Wisconsin: Buffalo, Pepin, Pierce, Polk and St. Croix

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior 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.

***Includes the following zip codes:*

Olmsted County	**Fillmore County**	**Wabasha County**	**Mille Lacs County**
55901	55922	55041	55371
55902	55923	55932	56313
55903	55939	55945	56330
55904	55949	55956	56353
55905	55954	55957	55363
55906	55962	55964	
55920	55986	55968	
55929		55978	
55934		55981	
55960		55991	
55976			

Section 2. How we change for 2002

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

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- Your share of the non-Postal premium will increase by 16.1% for Self Only or 14.5% for Self and Family.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We now cover certain intestinal transplants (Section 5(b))
- We increased our coverage of tobacco cessation product to include 180-day limit.
- We increased the office visit copay from $10 to $15 per visit.
- We now require a $15 copay per visit for allergy testing and treatment. You pay nothing for allergy injections and serum.
- We now use a formulary for the prescription drug benefit. The copays increased from $8 per prescription unit or refill to $10 for formulary and $20 for non-formulary prescription units or refills. The copay for mail order drugs increased from $16 for up to a 90-day supply to $20 for mail order formulary and $40 for mail order non-formulary drugs for up to a 90-day supply.
- We increased the emergency room copay from $40 per visit to $50 per visit for emergency care you receive within our service area.
- We decreased the benefit for oral contraceptives from one copay for 3 cycles of drugs, to one copay per cycle.
- We clarified that we cover wigs required due to hair loss caused by alopetia areata with 20 percent coinsurance and a maximum Plan payment of $350 per calendar year.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 952/883-5000 or 1-800-883-2177 (hearing impaired individuals should call 952/883-5127).

Where you get covered care

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

• Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. We are a mixed model prepayment plan which allows members to receive health services from individual doctors who practice out of their own offices and through 600 medical clinics and 137 contracting hospitals throughout the Twin Cities and surrounding areas. Our medical providers include more than 2,000 primary care doctors and over 2,600 community specialist to whom patients are referred. Members may choose any medical center in the plan network to receive primary care services. Each covered person in a family may select a different medical center.

We list Plan providers in the provider directory, which we update periodically.

•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.

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. To choose a primary care physician, call your clinic. Each covered person in a family may select a different medical center as their primary care clinic.

•Primary care

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

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

• Specialty care

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, a woman may see a plan gynecologist associated with her clinic for her annual wellness exam without a referral.

Here are other things you should know about specialty care:

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

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

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

- If you have a chronic or disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause; or

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  - reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

• Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 952/883-5000 or 1-800-883-2177 (hearing impaired individuals should call 952/883-5127). If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or

- The day your benefits from your former plan run out; or

- The 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process prior authorization. Your Plan physician must obtain prior authorization for services, such as:

- reconstructive surgery
- promising therapies/new technologies
- transplants
- medically necessary dental care, such as orthagnathic surgery
- durable medical equipment and prosthetics
- home health care
- skilled nursing care
- hospice care
- habilitative therapy

There may be additional services for which we require prior authorization. Your Plan physician is responsible for obtaining prior authorization.

Section 4. Your costs for covered services

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

• **Copayments**	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Example: When you see your primary care physician you pay a copayment of $15 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. Expenses you incur for any other services do not apply to this deductible. • We have a separate deductible for accidental injury dental benefits. Expenses you incur for any other services do not apply to this deductible. Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan.
•**Coinsurance**	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our Plan, you pay 20% of our allowance for infertility services and durable medical equipment.
• **Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments**	After your copayments and/or coinsurance total $3,000 per person or $5,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. Be sure to keep accurate records of your copayments and/or coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 59 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 952/883-5000 or 1-800-883-2177 (hearing impaired individuals should call 952/883-5127) or at our website at www.healthpartners.com.

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

IMPORTANT

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

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Plan physicians must provide or arrange your care.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians In physician's office In an urgent care center Office medical consultations Second surgical opinion	$15 per office visit
Professional services of physicians During a hospital stay In a skilled nursing facility	Nothing
Not covered: genetic counseling and studies not required for diagnosis and treatment.	*All charges*
Lab, X-ray and other diagnostic tests	
Tests, such as: Blood tests Urinalysis Non-routine pap tests Pathology X-rays Non-routine Mammograms CT Scans/MRI Ultrasound Electrocardiogram and EEG	Nothing

Preventive care, adult	You pay
Routine health exams, periodic health assessments, and cancer screenings, such as: Total Blood Cholesterol – once every three years Colorectal Cancer Screening, including Fecal occult blood test Sigmoidoscopy, screening – every five years starting at age 50 Prostate Specific Antigen (PSA test) – one annually for men age 40 and older Routine pap test Testing and treatment of sexually transmitted diseases and testing for HIV and HIV related conditions provided by a Plan or non-Plan provider Routine hearing and eye exams	Nothing
Routine mammogram –covered for women age 35 and older, as follows: From age 35 through 39, one during this five year period From age 40 through 64, one every calendar year At age 65 and older, one every two consecutive calendar years Adult immunizations Note: The above frequency guidelines are minimum benefits offered under the Plan. These services may be provided more frequently if they are medically necessary.	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Preventive care, children	
Childhood immunizations recommended by the American Academy of Pediatrics. Child health supervision services, including well-child care charges for routine examinations, immunizations and care (through age 22). Routine hearing and eye exams.	Nothing

Maternity care	You pay
Complete maternity (obstetrical) care, such as: Prenatal care Postnatal care	Nothing
Delivery Note: Here are some things to keep in mind: You do not need to prior authorize your normal delivery; see below for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. We pay hospitalization and surgeon services (delivery) the same as for illness and injury	See Hospital benefits (Section 5c) and Surgery benefits (Section 5b)
Not covered: Routine sonograms to determine fetal age, size or sex.	*All charges*
Family planning	
A broad range of voluntary family planning services, such as: Family planning services by a Plan or non-Plan provider	Nothing
Voluntary sterilization	$15 per office visit Nothing for inpatient or outpatient hospital
Surgically implanted contraceptives (such as Norplant) Injectable contraceptive drugs (such as Depo provera) Intrauterine devices (IUDs) NOTE: We cover oral contraceptives and diaphragms under the prescription drug benefit.	20% of charges
Not covered: reversal of voluntary surgical sterilization or genetic counseling,	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: Artificial insemination: *intravaginal insemination (IVI)* *intracervical insemination (ICI)* *intrauterine insemination (IUI)* Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. We cover the diagnosis of infertility services provided by a Plan or non-Plan provider.	20% of charges
Not covered: *Assisted reproductive technology (ART) procedures, such as:* *in vitro fertilization* *embryo transfer, gamete GIFT and zygote ZIFT* *Zygote transfer* *Services and supplies related to excluded ART procedures* *Cost of donor sperm or ova* *Cost of storage of donor sperm, ova or embryo* *Treatment of infertility after reversal of sterilization* *Artificial insemination for surrogate pregnancy*	*All charges*
Allergy care	
Testing and treatment	$15 per office visit
Allergy injection and serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 28. Respiratory and inhalation therapy Dialysis – Hemodialysis and peritoneal dialysis Intravenous (IV)/Infusion Therapy	$15 per office visit Nothing for inpatient or outpatient hospital
Blood and blood plasma (unless replaced) and blood derivatives for the treatment of blood disorders	Nothing
Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: – We will only cover GHT when your Plan physician prior authorizes the treatment. 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.	20% of charges
Not covered: Growth hormones which are not for growth hormone deficiency or chronic renal insufficiency.	*All charges*

Physical and occupational therapies	You pay
Two months per condition for the services of each of the following: qualified physical therapists and occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. You must achieve significant functional improvement, within a predictable period of time (generally within a period of two months), toward your maximum potential ability to perform functional daily living activities. Habilitative care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and motor development. Note: To be considered habilitative, significant functional improvement and measurable progress must be made toward achieving functional goals and your maximum potential ability, within a predictable period of time. We will supplement and coordinate such services with similar benefits made available by other agencies, including the public school system. Our Plan Medical Director will determine whether measurable progress has been made based on objective documentation.	$15 per office visit Nothing for inpatient or outpatient hospital
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for Phase I. Phase II is provided if we determine it is medically necessary. Phase III is not covered.	$15 per office visit Nothing for inpatient or outpatient hospital
Not covered: *exercise programs*	*All charges*

Speech therapy	You pay
Speech therapy for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech development or for restoration of speech. Note: To be considered habilitative, significant functional improvement and measurable progress must be made toward achieving functional goals and your maximum potential ability, within a predictable period of time. We will supplement and coordinate such services with similar benefits made available by other agencies, including the public school system. Our Plan Medical Director will determine whether measurable progress has been made based on objective documentation.	$15 per office visit Nothing for inpatient or outpatient hospital
Hearing services (testing, treatment, and supplies)	
First hearing aid and testing only when necessitated by accidental injury Hearing testing (see *Preventive care, adults and children*)	Nothing
Not covered: *all other hearing testing* *hearing aids, testing and examinations for them*	*All charges*

Vision services (testing, treatment, and supplies)	You pay
Diagnosis and treatment of illness and injury to the eye; and	$15 per office visit
Initial evaluation, lenses and fitting for contact or eyeglass lenses if medically necessary for the post-surgical treatment of cataracts or for the treatment of aphakia or keratoconous	$15 per office visit All charges for lens replacement beyond the initial pair.
Eye exam to determine the need for vision correction (see preventive care). Annual eye refractions Note: See Preventive care, children for eye exams for children.	Nothing
Not covered: *Eyeglasses or contact lenses and, except as described above* *Eye exercises* *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
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.	$15 per office visit
Not covered: *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).*	*All charges*

Orthopedic and prosthetic devices	You pay
We cover the following: Orthopedic devices, such as braces and foot orthotics; Prosthetic devices, such as artificial limbs and eyes; Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy; Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device; and Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. Orthopedic and corrective shoes when approved by Plan based on our criteria	20% of charges
Wigs required due to hair loss caused by alopetia areata up to a maximum Plan payment of $350 per calendar year.	20% of charges, and all charges beyond the $350 calendar year limit
Not covered: *over-the-counter foot orthotics* *replacement or repair of any covered items if they are damaged or destroyed by member misuse, abuse or carelessness; lost; or stolen.* *duplicate or similar items.* *items which are primarily educational in nature or for vocation, comfort, convenience or recreation.*	*All charges*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: hospital beds; wheelchairs; crutches; walkers; blood glucose monitors; and insulin pumps.	20% of charges
Not covered: *replacement or repair of any covered items if they are damaged or destroyed by member misuse, abuse or carelessness; lost; or stolen.* *duplicate or similar items.* *items which are primarily educational in nature or for vocation, comfort, convenience or recreation.* *household equipment, such as exercise cycles, air purifiers, water purifiers, air conditioners, non-allergenic pillows, mattresses or water beds.* *household fixtures, such as escalators or elevators, ramps, swimming pools or saunas.* *modifications to the home, such as wiring, plumbing or charges to install equipment.* *vehicle, car or van modifications, such as hand brakes, hydraulic lifts and car carriers.* *Rental of medically necessary durable medical equipment while member's equipment is being repaired, beyond one month rental*	*All charges*
Home health services	
We cover home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or home health aide, as shown below:	
Physical therapy, occupational therapy, speech therapy, respiratory therapy and home health aide services.	$15 per visit
TPN/intravenous therapy, skilled nursing services, prenatal and postnatal services, child health services, and phototherapy.	Nothing
Not covered: *nursing care requested by, or for the convenience of, the patient or the patient's family;* *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*

Chiropractic	You pay
Chiropractic services for rehabilitative care, provided to diagnose and treat acute neuromusculo-skeletal conditions, limited to: Manipulation of the spine and extremities Adjunctive procedures such as message therapy, ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application, when they are performed in conjunction with other treatment by a chiropractor, are part of a prescribed treatment plan and are not billed separately	$15 per office visit
Not covered: Naturopathic services Hypnotherapy	*All charges*
Alternative treatments	
We cover the following services: Acupuncture – by a certified Plan acupuncturist for: anesthesia pain management chemical dependency headaches nausea Biofeedback for: incontinence headaches musculo-skeletal spasms which do not respond to other treatments mental/nervous disorders neurological retraining	$15 per office visit
Not covered: *naturopathic services* *hypnotherapy*	*All charges*
Educational classes and programs	
We cover education for preventive services and smoking cessation.	Nothing
We cover education for the management of chronic health problems (such as diabetes)	$15 per office visit/session

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

IMPORTANT

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

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Plan physicians must provide or arrange your care.

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 described in this section are for the charges billed by a physician or other health care professional for your surgical care. The amount that you pay for these services depends on where the services are provided and follow the benefits described in Section 5 (a) and (c), unless otherwise specified below.

YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: Operative procedures Treatment of fractures, including casting Normal pre- and post-operative care by the surgeon Correction of amblyopia and strabismus Endoscopy procedures Biopsy procedures Removal of tumors and cysts Correction of congenital anomalies (see reconstructive surgery) Surgical treatment of morbid obesity Insertion of internal prosthetic devices. See 5(a) – Orthopedic and Prosthetic devices for device coverage information. (See note below)	$15 per office visit Nothing for inpatient or outpatient hospital
Voluntary sterilization Treatment of burns *Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and for insertion of the pacemaker.	$15 per office visit Nothing for inpatient or outpatient hospital
Not covered: *Reversal of voluntary sterilization* *Routine treatment of conditions of the foot; see Foot care.*	*All charges*

Reconstructive surgery	You pay
Surgery to correct a functional defect Surgery to correct a condition caused by injury or illness if: the condition produced a major effect on the member's appearance and the condition can reasonably be expected to be corrected by such surgery Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; port wine stains*; webbed fingers; and webbed toes. * Note: port wine stains do not have to result in a functional defect to be covered.	$15 per office visit Nothing for inpatient or outpatient hospital
All stages of breast reconstruction surgery following a mastectomy, such as: surgery to produce a symmetrical appearance on the other breast; treatment of any physical complications, such as lymphedemas; breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* *Surgeries related to sex transformation, unless determined medically necessary by the Plan Medical Director*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: Reduction of fractures of the jaws or facial bones; Surgical correction of cleft lip, cleft palate (limited to dependent children to age 18); Removal of stones from salivary ducts; Excision of leukoplakia or malignancies; Excision of cysts and incision of abscesses when done as independent procedures; and Other surgical procedures that do not involve the teeth or their supporting structures, including non-dental treatment of temporomandibular joint dysfunction (TMJ).	$15 per office visit Nothing for inpatient or outpatient hospital
Orthognathic surgery for the treatment of a skeletal malocclusion when a functional occlusion cannot be achieved through non-surgical treatment alone and a demonstrable functional impairment exists.	*25% of charges*
Not covered: *Oral implants and transplants* *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* *Orthodontic services (pre or post operative) associated with orthognathic surgery.*	*All charge*

Organ/tissue transplants	You pay
Transplant services are covered at our designated centers of excellence for transplants and are limited to: Cornea Heart Heart/lung Kidney Kidney/Pancreas for diabetes Liver, for bilary atresia ion children, primary bilary cirrhosis, post acute viral infection (including hepatitus A, hepatitus B anitgen e negative and hepatitus C) causing acute atrophy or post necrotic cirrhosis, primary sclerosing cholangitis and alcoholic cirrhosis Lung: Single – Double, for primary pulmonary hypertension, Eisenmenger's syndrome, end stage pulmonary fibrosis, alpha 1 antitrypsin disease, cystic fibrosis and emphysema Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; Hodgkin's lymphoma; non-Hodgkin's lymphoma; Burkitt's lymphoma; neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Allogenic (donor) bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for acute myelogenous leukemia; acute lymphotytic leukemia; chronic myelogenouis leukemia; severe combined immunodeficiency disease; Wiscott-Aldrich syndrome; and aplastic anemia Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: *Donor screening tests and donor search expenses, except those performed for the actual donor* *Implants of artificial organs* *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
Professional services provided in – Hospital (inpatient)	Nothing
Professional services provided in – Ambulatory surgical center	Nothing
Professional services provided in -- Hospital outpatient department Skilled nursing facility Office	$15 per visit

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

IMPORTANT

Here are some important things to remember about these benefits:

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as ward, semiprivate, or intensive care accommodations; general nursing care; and meals and special diets. Other hospital services and supplies, such as: Operating, recovery, maternity, and other treatment rooms – Prescribed drugs and medicines Diagnostic laboratory tests and X-rays Administration of blood and blood products Blood and blood plasma (unless replaced) and blood derivatives Dressings, splints, casts, and sterile tray services Medical supplies and equipment, including oxygen Anesthetics, including nurse anesthetist services Take-home items Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Not covered: *Custodial care* *Non-covered facilities, such as nursing homes, extended care facilities, schools* *Personal comfort items, such as telephone, television, barber services, guest meals and beds* *Private nursing care*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay
Operating, recovery, and other treatment rooms – Prescribed drugs and medicines Diagnostic laboratory tests, X-rays, and pathology services Administration of blood, blood plasma, and other biologicals Blood and blood plasma (unless replaced) and blood derivatives 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.	Nothing
Extended care benefits/skilled nursing care facility benefits	
We cover a comprehensive range of benefits for up to 180 days per period of confinement when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by your Plan physician and prior authorized by this Plan. All necessary services are covered, including: Bed, board and general nursing care Drugs, biologicals, services and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your Plan doctor. Period of confinement means (1) continuous stay in a hospital or skilled nursing facility, or (2) a series of two or more stays in a hospital or skilled nursing facility for the same condition in which the end of each inpatient stay is separated from the beginning of the next one by less than 90 days. Same condition means illness or injury related to a former illness or injury that is (1) within the same ascertainable diagnosis, or (2) within the scope of complications, or related conditions.	Nothing
Not covered: custodial care	*All charges*

Hospice care	You pay
We cover supportive and palliative care in your home or a hospice facility if you are terminally ill. We cover the following services:	
Outpatient care, family counseling and continuous care*.	Nothing
Inpatient care.	Nothing
Respite care*. * Note: Respite care is limited to 5 days per episode, and respite care and continuous care combined are limited to 30 days.	20% of charges
Not covered: independent nursing, homemaker services	*All charges*
Ambulance	
Ambulance and medical transportation for medical emergencies described in section 5(d).	20% of charges
Prior authorized transfers between network hospitals for treatment if initiated by a Plan physician.	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you need emergency care, call your clinic, or call the CareLine℠ nurse after hours at 612/339-3663 (hearing impaired individuals should call 952/883-5474). The service nurse or Plan physician will recommend how, when and where to obtain the appropriate treatment. In extreme emergencies, if you are unable to contact your primary care doctor or clinic or the CareLine℠ nurse, contact the local emergency system (e.g., 911 telephone system) or go to the nearest hospital emergency room.

Emergencies outside our service are: You must notify us within two days of admittance to an out-of-network hospital, or as soon as reasonably possible under the circumstances. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Emergency within our service area	You pay
Emergency care and urgent care at a doctor's office	$15 per office visit
Emergency care and urgent care as an outpatient at a hospital, including doctors' services Note: copay waived if admitted to the hospital for the same condition within 24 hours.	$50 per office visit
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
Emergency care and urgent care at a doctor's office Emergency care and urgent care at an urgent care center Emergency care and urgent care as an outpatient at a hospital, including doctors' services	20% of the first $2,500 of charges per calendar year
Emergency admission to an out of area hospital, including doctors' services	20% of the first $2,500 of charges per calendar year
Not covered: *Elective care or non-emergency care* *Emergency or urgently needed 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	
Ambulance and medical transportation for medical emergencies described in Section 5(d). Note: air ambulance is covered if medically necessary.	20% of charges

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

IMPORTANT

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

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

All benefits are subject to the definitions, limitations, and exclusions in this brochure.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION OF THESE SERVICES. See the instructions after the benefits descriptions below.

IMPORTANT

Benefit Description	You pay
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: In-network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
Professional services, including individual by providers such as psychiatrists, psychologists, or clinical social workers Medication management	$15 per office visit
Group therapy	$7.50 per office visit
Diagnostic tests	Nothing
Services provided by a hospital or other facility Services in approved alternative care settings such as: Residential treatment Partial hospitalization or full-day hospitalization for mental health services	Nothing

Mental health and substance abuse benefits *(continued)*	**You pay**
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*

Prior authorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

You do not need a referral from your primary care Physician to obtain mental or substance abuse services. You must use a mental or substance abuse provider that is in our Plan network and associated with your clinic. We list the mental and substance abuse providers associated with your clinic's care system in our provider directory. If you have questions or need a provider directory, call HealthPartners Member Services Department at 952/883-5000 or 1-800-883-2177 (hearing impaired individuals should call 952/883-5127).

Limitation

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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

We cover prescribed drugs and medications, as described in the chart beginning on the next page.

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

Who can write your prescription. A plan or referral physician must write the prescription.

Where you can obtain them. You must fill the prescription at a plan pharmacy or by mail.

We use a formulary. However, we cover non-formulary drugs prescribed by a Plan doctor. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost.

These are the dispensing limitations. Unless otherwise specified in this section, you may receive up to a 30-day supply per prescription. No more than a 90-day supply will be covered and dispensed at a time. A generic equivalent will be dispensed if available, unless your physician specifically requires a name brand. If a copayment is required, you must pay one copayment for each 30-day supply, or portion thereof, or for each manufacturer's pre-packaged dispensing unit (but not less than what your doctor recommends is a 30-day supply), except as follows:

For insulin a copay will apply per vial or box of insulin cartridges.

For contraceptive barrier devices, a copayment will apply per device.

For Mail order drugs, see benefit described below.

If you request a refill too soon after the last one was filled, it may not be filled at that time. It may require up to 14 days to get mail order prescriptions filled, so this service is best for maintenance drugs, not for drugs you need immediately or for drugs you are taking on a short-term basis. Federal or state regulations may prevent us from filling certain prescriptions through our mail order service, such as laws which prohibit us from sending narcotic drugs across state lines.

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 may have to pay the difference in cost between the name brand drug and the generic.

Why use generic drugs? Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original name brand product. Generic drugs cost you and your plan less money than a name brand drug.

When you have to file a claim. You do not need to file a claim for drugs obtained at a network pharmacy or through our mail order service. You would need to file a claim for prescription drugs covered as part of an out-of-area emergency, if you did not get them at a network pharmacy. See section 7 for instructions on filing a claim.

Prescription drug benefits begin on the next page.

Covered medications and supplies	You pay
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase Insulin, with a copay applied per vial Diabetic testing supplies (see glucose monitors under Durable Medical Equipment) Disposable needles and syringes for the administration of covered medications Drugs for sexual dysfunction (see Limited Benefits below) Oral contraceptive drugs and contraceptive barrier devices; a single copay charge will apply for 1 cycle of oral contraceptive drugs or for each barrier device Tobacco cessation products, as determined by this Plan, limited to a 180-day supply per calendar year. No more than a 30-day supply will be covered and dispensed at a time.	$10 copay for formulary drugs $20 copay for non-formulary drugs
Mail order benefits	
You may also get outpatient prescription drugs which can be self-administered through HealthPartners mail order service. For information on how to obtain drugs through HealthPartners mail order service, please call our Member Services Department at 1-800/883-2177 (hearing impaired individuals should call 952/883-5127). This benefit does not apply to drugs listed under Limited Benefits below.	$20 copay for formulary drugs $40 copay for non-formulary drugs

Limited benefits	
Injectable or implantable contraceptive drugs or devices (such as, Depo Provera, Norplant, IUDs) Growth hormones Injectable drugs for the treatment of infertility Special dietary treatment for phenylketonuria (PKU) Drugs to treatment of sexual dysfunction are limited to six doses per month.	20% of charges
Not covered: *Drugs and supplies for cosmetic purposes* *Vitamins, nutrients and food supplements even if a physician prescribes or administers them, except as specified* *Nonprescription medicines* *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* *Medical supplies such as dressings and antiseptics* *Drugs to enhance athletic performance*	*All Charges*

Section 5 (g). Special features

Feature	Description
CareLine[sm] nurse line	When you call the CareLine after regular clinic hours, you reach a skilled nurse who is specially trained to assess medical conditions of all kinds. Call 612/339-3663 or 1-800-551-0859 and talk with a registered nurse who will discuss treatment options and answer your health questions.
BabyLine[sm] Service	If you're an expecting or new parent and have questions after regular clinic hours, our BabyLine service is just for you. BabyLine is staffed by obstetric nurses who can help with questions relating to pregnancy, new baby care, nursing and postpartum concerns. Call 612/333-BABY (333-2229) or 1-800-845-9297.
Partners for Better Health Phone Line	The HealthPartners Partners for Better Health Phone Line is a special service designed to help you improve your health, prevent disease and lead a healthier lifestyle. When you call 952/883-7800 weekdays between 8 a.m. and 6 p.m., you will speak directly with a health educator or registered dietitian who will help you develop a personalized action plan to make healthier choices in you daily routine. You can also register for health education classes, learn about member discounts for many health and safety products, plus much more.
Services for deaf and hearing impaired	If you are deaf or hearing impaired, we have phone lines which you may call for the following services: Member Services: 952/883-5127 CareLine[sm] Service: 952/883-5474 Baby Line[sm] Service: 952/883-5127 Partners for Better Health: 952/883-7498

Section 5 (h). Dental benefits

IMPORTANT

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

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Plan dentists must provide or arrange your care.

There is a $50 calendar year deductible for emergency accidental dental services provided by non-Plan dentists.

We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Dental benefits	**You pay**
We cover preventive and diagnostic dental services shown below for all members when provided by Plan dentists. Benefit limits are noted where they apply. Routine dental examinations (per Plan dentist's recommendation); Teeth cleaning, prophylaxis or periodontal maintenance recall (limited to twice per calendar year); Topical application of fluoride (per Plan dentist's recommendation); Oral hygiene instruction (per Plan dentist's recommendation); Bitewing x-rays (limited to once per calendar year); and Full mouth (panoramic) x-rays (limited to once every three calendar years).	Nothing
Not covered: other dental services not shown as covered.	*All charges*
Accidental injury benefit	
We cover restorative services and supplies provided by Plan dentists necessary to promptly repair or replace sound natural teeth, including the cost and installation of necessary prescription dental prosthetic items or devices. The need for these services must directly result from an accidental injury, not including injury from biting or chewing, and the treatment or repair must be initiated within twelve months of the date of injury.	Nothing
Emergency dental services for accidental injury, as described above, are covered when they are provided by non-Plan dentists if the services require immediate treatment.	$50 calendar year deductible, then 20% of the charges, up to a maximum benefit of $300 per calendar year, and any charges thereafter.
Not covered: any dental services rendered in connection with previously missing teeth or for teeth not injured in the accident. *other dental services not shown as covered.*	*All charges*

Section 5 (i). 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 out-of-pocket maximums.

Medicare prepaid plan enrollment – This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare without payment of an FEHB premium. As indicated on page 49, certain annuitants and former spouses who are covered by both Medicare Parts A and B and FEHB may elect to drop their FEHB coverage and later reenroll in FEHB. Contact your retirement system for information on changing your FEHB enrollment. Call us at 952/883-5600 for information on the Medicare prepaid plan and the cost of enrollment.

Expanded Provider Network Option

An Expanded Provider Network (EPN) option is available to you as a member of this HealthPartners medical plan. The EPN option offers a network of allied health care professionals in addition to the network available under your medical plan. EPN health care professionals include audiologists, chiropractors, home health care providers, mental health providers, occupational therapists, optometrists, physical therapists, podiatrists and speech therapists.

The EPN option is offered as a rider, or "add-on," to your current medical plan. You have the opportunity to purchase the EPN rider within 31 days of enrolling in this Plan and annually at the beginning of each year.

The EPN option **does not increase or change the benefits** under this Plan. The coverage, limitations and exclusions are the same as this Plan with a per visit copayment for care received from an EPN provider. There is a monthly cost to you for enrolling in the EPN option.

For a complete EPN Information Packet, including benefit summary, rates, provider listing and enrollment form, please call HealthPartners Member Services at 952-883-5000 or the toll-free number at 1-800-883-2177. If you have additional questions about the EPN option after you receive your packet, please call Member Services.

Benefits on this page are not part of the FEHB Contract.

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations unless determined medically necessary by the Plan Medical Director; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

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

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

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 952/883-5000 or 1-800-883-2177 (hearing impaired individuals should call 952/883-5127).

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

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

Submit your claims to: **HealthPartners claims**
P.O. Box 1289
Minneapolis, MN 55440-1289

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: HealthPartners, Member Services, P.O. Box 1309, Minneapolis, MN 55440-1309; 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.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, D.C. 20415-3610.

The Disputed Claims process (*Continued)*

Send OPM the following information:

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

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 952/883-5000 or 1-800-883-2177 (hearing impaired individuals should call 952/883-5127) and we will expedite our review; or

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

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

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

- **What is Medicare?**

Medicare is a Health Insurance Program for:
•• People 65 years of age and older.
•• Some people with disabilities, under 65 years of age.
•• People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:
•• Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or order, you may be able to buy it. Contact 1-800-MEDICARE for more information.

•• Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

- **The Original Medicare Plan**

The Original Medicare Plan (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. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. You must coordinate your care with your Plan primary care physician, who will authorize your referrals to Plan specialists and prior authorize services with the Plan, as specified under Section 3.

We will waive any of our copayments, coinsurance and deductibles.

(Primary payer chart begins on next page.)

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

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or……	……✓	
b) The position is not excluded from FEHB…….	…….	……✓
(Ask your employing office which of these applies to you.)		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or……	……...✓	
b) Are an active employee, or……	……..	……..✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

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

- When we are the primary payer, we process the claim first.
- When original Medicare is the primary payer, medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered cahrges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 952/883-5000 or 1-800-883-2177 (hearing impaired individuals should call 952/883-5127) or at our website at www.healthpartners.com.

We waive some costs when you have the Original Medicare Plan -- When Original Medicare is the primary payer we will waive any of our copayments, coinsurance and deductibles.

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

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

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

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

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

• If you do not enroll in Medicare Part A or Part B If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium free Part A, we will not ask you to enroll in it.

TRICARE

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

Workers' Compensation

We do not cover services that:

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

If you do not seek damages you must agree to let us try. This is called subrogation.

This Plan will be entitled to immediately collect the present value of subrogation rights from any recovery payments you receive, whether or not you have been fully compensated for your losses and damages. Unless we agree,, you may not deduct attorneys' fees and expenses, which you incur in the recovery of monies from a third party, from the subrogation/reimbursement amounts.

If you need more information, contact us for our subrogation procedures.

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.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Covered services

Care we provide benefits for, as described in this brochure.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or investigational services

This Plan determines if a treatment or procedure is experimental/investigative or unproven if it is:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use; or
- If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III Clinical Trials; or
- If reliable evidence shows that the drug, device or medical treatment or procedure is under study to determine its maximum tolerated dose, its toxicity, its safety, and its efficacy as compared with the standard means of treatment or diagnosis.

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 as follows:

For covered services delivered by Plan providers, or Plan referral providers, our allowance is the provider's discounted charge for a given medical/surgical service, procedure or item, which Plan providers have agreed to accept as payment in full.

For covered services delivered by non-Plan providers, our allowance is the provider's charge for a given medical/surgical service, procedure or item, according to the fair and reasonable charge amount.

The Fair and Reasonable Charge is the maximum amount we allow when we calculate the payment for charges incurred for covered services provided by non-Plan providers. It is consistent with what other providers in the same community charge for a given service or item, as defined by the Health Insurance Association of America (HIAA) schedule.

Us/We

Us and we refer to HealthPartners Primary Clinic Plan

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about:

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

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

Types of coverage available for you and your family

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

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

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

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you 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. Annuitants' coverage and premiums begin January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

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

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

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

•Temporary Continuation of Coverage (TCC)

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

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

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

•Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover all their long-term care needs. Unfortunately, they are WRONG!
- How are YOU planning to pay for the future custodial or chronic care you may need? Consider buying long term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but you should have a plan just in case. *LTC insurance may be vital to your financial and retirement planning.*

Is long term care expensive?

- Yes, a year in a nursing home can exceed $50,000 and only three 8-hour shifts a week can exceed $20,000 a year, that's before inflation!
- TLC can easily exhaust your savings but LTC insurance can protect it.

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look under "*Not covered"* blocks in sections 5(a) and 5(c) of your FEHB brochure. Custodial care, assisted living, or continuing home health care for activities of daily living are not covered. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care after a hospitalization with a 100 day limit.
- Medicaid covers LTC for those who meet their state's guidelines, but restricts covered services and where they can be received. LTC insurance can provide choices of care and preserve your independence.

When will I get more information?

- Employees will get more information from their agencies during the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- A toll-free telephone number will begin in mid-2002. You can learn more about the program now at www.opm.gov/insure/ltc.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2002. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2001 open season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during open season. Your coverage will begin January 1, 2002. If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

TCC eligibility

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

Index

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

Summary of benefits for the HealthPartners Primary Clinic Plan - 2002

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	$15 per office visit primary care; $15 per office visit specialist	14
Services provided by a hospital: • Inpatient ..... • Outpatient.....	Nothing. Nothing.	25 25
Emergency benefits: • In-area ..... • Out-of-area.....	$50 Emergency Room visit $15 Urgent Care Center visit 20% of the first $2,500; nothing thereafter	34 34
Mental health and substance abuse treatment.....	Regular cost sharing	35
Prescription drugs.....	$10 copay for formulary $20 copay for non formulary per prescription unit or refill (mail order benefit is two copays per 90-day supply)	37
Dental Care.....	Nothing for preventive care.	41
Vision Care.....	Nothing	21
Special features:	CareLine℠ nurse line, BabyLine℠ Service, Partners for Better Health Phone Line, Services for deaf and hearing impaired.	40
Protection against catastrophic costs (your out-of-pocket maximum).....	$3,000 /Self Only or $5,000 /Family per calendar year	12

2002 Rate Information for HealthPartners Primary Clinic Plan

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

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Minneapolis – St. Paul – St. Cloud – South Central Minnesota – West Central Wisconsin

Self Only	HQ1	$97.86	$68.10	$212.03	$147.55	$115.52	$50.44
Self and Family	HQ2	$223.41	$174.90	$484.06	$378.95	$263.75	$134.56