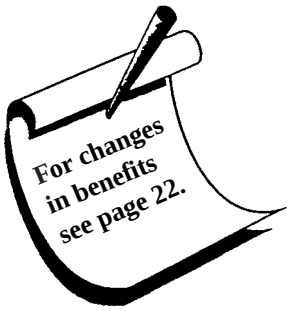
HealthPartners®

HealthPartners Classic 1999

A Health Maintenance Organization



Serving: Greater Minneapolis - St. Paul - St. Cloud

Enrollment Codes:
531 High Option Self Only
532 High Option Self and Family
534 Standard Option Self Only
535 Standard Option Self and Family

This plan has full accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.

Enrollment in this Plan is limited; see page 9 for requirements.

Visit the OPM website at http://www.opm.gov/insure

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73-009

HealthPartners Classic

Group Health, Inc., dba as HealthPartners Classic, 8100 34th Avenue South, Minneapolis, Minnesota 55440, has entered into a contract (CS 1048) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called HealthPartners Classic or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on page 22 of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 612/883-5000 or 1-800/883-2177 (hearing impaired individuals should call 1-612/883-5127) and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W. Room 6400
Washington, D. C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 15. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See *"If you are hospitalized"* on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The **benefits** in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new **rates** are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.

Things to keep in mind
continued

- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

  Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

  You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

  Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. See page 20 for information on the Medicare prepaid plan offered by this Plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

General Information *continued*

Notification and election requirements

Separating employees — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Facts about This Plan

This Plan is a comprehensive medical plan, sometimes called a Health Maintenance Organization or HMO. When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors and hospitals to give care to members and pays them directly for their services. Benefits are available **ONLY** from Plan providers except during a medical emergency. **Members are required to select a personal doctor from among participating Plan primary care doctors.** Services of a specialty care doctor can only be received by referral from the selected primary care doctor. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan both provides your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling HealthPartners Member Services Department at 612/883-5000 or 1-800/883-2177 (hearing impaired individuals should call 612/883-5127), or you may write the Plan at HealthPartners Member Services Department, 8100 34th Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If non-compliant, the reasons for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Who provides care to Plan members?

Members of the Plan receive health services at over 70 medical, mental health and dental facilities and 25 contracting hospitals throughout the Twin Cities and surrounding areas including St. Cloud. HealthPartners Classic medical providers include 575 primary care doctors and over 1,100 community specialists to whom patients are referred. Members may choose any medical center in the Plan's network for their primary care. Each covered person in a family may select a different medical center.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, generally are obtained. Plan members must obtain all of their medical care, including emergency care when possible, in Plan facilities. Members are encouraged to select a primary care doctor (generally a pediatrician, an internist or a family practice doctor) who will provide most of their medical care and refer them to other medical specialists when necessary.

Services of other providers are covered only when you have been referred by your primary care doctor, with the following exception: a woman may see a Plan gynecologist associated with her clinic for her annual routine examination without a referral.

Choosing your doctor

The locations and telephone numbers of all medical centers are provided in a separate directory. Directories are provided to all enrollees at the time of enrollment or upon request by calling the Customer Service Department at 612/883-5000 or 1-800/883-2177 (hearing impaired individuals should call 1-612/883-5127). Directories are subject to change without notice and are updated on a quarterly basis.

Whether you are already a Plan member or are considering enrolling in this Plan, you should review the Plan's provider directory. If you are interested in receiving care from a specific provider, you should call the provider to verify that he or she still participates with the Plan and is accepting new patients. **It is important to know that when you enroll in this Plan, services are provided through the Plan's delivery system, but the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.** Should you decide to enroll, you will be asked to complete a primary clinic selection form and send it directly to the Plan, indicating the name of the primary clinic(s) selected for you and each member of your family. Members may change their clinic selection by notifying the Plan. Any change of your clinic will be effective the first of the following month after the Plan receives your request, if the Plan receives it by the 20th of the month. Clinic changes may not be made during the time you are receiving inpatient services.

If you are receiving services from a doctor who terminates a participation agreement, the Plan will provide payment for covered services until the Plan can make reasonable and medically appropriate provisions for the assumption of such services by a participating doctor.

Facts about This Plan *continued*

Referrals for specialty care

Plan members are expected to obtain all of their medical care, including emergency care, in Plan facilities. Care may also be obtained through the community specialists and the hospitals that are referral providers for the Plan, but only after authorization and referral by a Plan doctor, Plan dentist or a Plan mental health professional. There are limited exceptions for emergency care. The Plan is not liable for and will not pay for unauthorized charges.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist.

Authorizations

Your primary care doctor must obtain authorization from the Plan before you may be hospitalized, referred for specialty care or obtain a follow-up care from a specialist. You should check with your Plan doctor to determine if a service requires a referral or authorization before you obtain services.

Plan medical directors, or their designees, make coverage determinations and make final authorization for certain covered services. Coverage determinations are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. Call the Plan for more information on referral and authorization requirements.

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan doctor for the care to be covered by the Plan. If the doctor who originally referred you prior to joining this Plan is now your Plan primary care doctor, you need only call to explain that you now belong to this Plan, and ask that a referral form be sent to the specialist for your next appointment.

If you are selecting a new Plan primary care doctor and want to continue with a specialist, you must schedule an appointment so the primary care doctor can decide whether to treat the condition directly, or refer you to a specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach $3,000 per Self Only enrollment or $5,000 per Self and Family enrollment under the High Option or $3,000 per Self Only enrollment or $5,000 per Self and Family enrollment under the Standard Option.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

Deductible carryover

If you changed to this Plan during **open season** from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

Experimental/ Investigative determinations

HealthPartners of Minnesota determines if a treatment or procedure is experimental, investigational 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, its efficacy as compared with the standard means of treatment or diagnosis.

The Plan's Service Area

The service area for this Plan, where Plan providers and facilities are located is described below. You must live or work in the service area to enroll in this Plan. Benefits for care outside the service area are limited to emergency services, as described on page 16 and as noted below.

If you or a covered member move outside the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

Service Area: Services from Plan providers are available only in the following area:

The metropolitan area and suburbs of Minneapolis - St. Paul - St. Cloud including the ***Minnesota*** counties of Anoka, Benton, Carver, Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Morrison, Ramsey, Rice, Scott, Sherburne, Stearns, Washington and Wright.

The southwest quarter of Crow Wing including the townships of Crow Wing, Daggett Brook, Fort Ripley, Long Lake, Maple Lake, Nokay Lake, Oak Lawn, Platte Lake and St. Mathias.

The southeast quarter of Douglas including the townships of Alexandria, Belle River, Carlos, and Osakis.

The following townships and cities in Kandiyohi County: Hawick, New London and Regal.

The following townships and cities in Pope County: Glenwood, Sedan, Villard and Westport.

The eastern one-third of Todd County including the townships and cities of Bruce, Burnhamville, Clarissa, Clotho, Fawn Lake, Gray Eagle, Hartford, Little Elk, Little Sauk, Long Prairie, Reynolds, Round Prairie, Turtle Creek and West Union.

The ***Wisconsin*** counties of Pierce, Polk and St. Croix.

Pre-authorized care for enrollees temporarily outside the Service Area

If a member has an illness or condition for which services may be required and the member will be temporarily leaving the service area, the Plan covers care from non-network providers if the care has been pre-authorized by the Plan's medical director or his or her designee. Coverage may include professional services from a non-network doctor and hospital services, which are for scheduled care which is immediately required and cannot be delayed. The Plan's medical director may limit the scope and duration of benefits provided under this provision. Services are covered at 80% of charges. Preventive services, such as routine physicals and checkups, services for mental and chemical health and children's emotional handicaps are not covered.

Members must contact their Plan doctor to receive direction on how, when and where to obtain the appropriate treatment.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan. This brochure is the official statement of benefits on which you can rely.

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Arbitration of claims

Any claim for damages for personal injury, mental disturbance or wrongful death arising out of the rendition or failure to render services under this contract must be submitted to binding arbitration.

Other sources of benefits

This section applies when you or a member of your family is entitled to benefits from another source besides this Plan. You must disclose information about other sources of benefits to the Plan and all necessary documents and authorizations must be completed as requested by the Plan.

Medicare

If you or a covered family member is enrolled in this plan and Medicare Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies or pre-authorized care for enrollees temporarily outside the service area, unless you use Plan providers. You must tell the Plan that you or your family member is eligible for Medicare. Generally, that is all you need to do, unless your Plan tells you that you need to file a Medicare claim.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits as a result of, any other group health coverage, or the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

General Limitations *continued*

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are payable under workers' compensation (under section 8103 of title 5, U.S.C.) or similar Federal or State laws, regardless of whether or not medical benefits have been applied for or paid under workers' compensation or similar provisions. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim (or potential claim) under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan.

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Veterans Administration, Department of Defense, and Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the definitions, limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness or condition. The following are excluded:**

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see *Emergency Benefits*)
- Expenses incurred while not covered by this Plan
- Services furnished or billed by a provider or facility barred from the FEHB Program
- Services not required according to accepted standards of medical, dental, or psychiatric practice
- Procedures, treatments, drugs or devices that are experimental or investigational
- Procedures, services and supplies related to sex transformations
- Procedures, services, drugs, and 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.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits.

High Option	Standard Option
You pay a $10 copay per office visit and per house call by a doctor but no additional copay for laboratory tests and X-rays.	**You pay** a $15 copay per office visit and per house call by a doctor but no additional copay for laboratory tests and X-rays.

The following services are included and are subject to the office visit copay unless stated otherwise:

- Preventive care, including well baby care and periodic check-ups, routine screening for cancer, routine eye and hearing exams and voluntary family planning services. **You pay** nothing.
- Routine immunizations and boosters. **You pay** nothing
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through age 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. **You pay** nothing for routine mammograms. In addition to routine screening mammograms are covered when prescribed by a Plan doctor as medically necessary to diagnose or treat your illness.
- Consultations by specialists
- Diagnostic procedures, including laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of the infant requiring definitive treatment will be covered only if the infant is covered under a Self and Family enrollment. **You pay** nothing for prenatal and postnatal care.
- Voluntary sterilizations and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials (such as allergy serum). **You pay** nothing for allergy injections.
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Cornea; heart; heart/lung or single and double lung for primary pulmonary hypertension, Eisenmenger's syndrome, end stage pulmonary fibrosis, alpha 1 antitrypsin disease, cystic fibrosis and emphysema; kidney/pancreas for type 1 uncontrolled diabetes; kidney; liver transplants for bilary atresia in children, primary bilary cirrhosis, post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post necrotic cirrhosis, primary sclerosing cholangitis and alcoholic cirrhosis; allogenic (donor) bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for acute myelogenous leukemia, acute lymphocytic leukemia, chronic myelogenous leukemia, severe combined immunodeficiency disease, Wiscott-Aldrich syndrome and aplastic anemia; autologous bone marrow transplants or peripheral stem cell support for acute lymphocytic and non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer, multiple myloma, epithelial ovarian cancer, and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Transplants are covered when approved by the Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Chiropractic services. Chiropractic therapy does not include ongoing maintenance therapy or therapy other than for treatment of acute musculoskeletal conditions.
- Breast reduction surgery, if approved by the Plan Medical Director.

What is covered
continued

- Surgical treatment of morbid obesity, if approved by the Plan Medical Director.
- Home health services of nurses and health aides, including intravenous fluids and medications when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need. **You pay** the office visit copay shown above per visit for health aides, physical therapists, occupational therapists, respiratory therapists and speech therapists. **You pay** nothing for all other covered home health services.
- Plan doctors also provide all necessary medical or surgical care in a hospital or extended care facility, at no additional cost to you.
- Non-Plan services for voluntary family planning, the diagnosis of infertility, testing and treatment of sexually transmitted diseases and testing for HIV and HIV-related conditions. **You pay** the same as you would for the applicable service provided by a Plan provider.

Limited benefits

Oral and maxillofacial surgery is provided for non-dental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical and surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures, treatment of tempomandibular joint (TMJ) pain disfunction syndrome and excision of tumors and cysts. Treatment of cleft lip and cleft palate, including orthodontia and oral surgery, is limited to dependent children to age 18. All other procedures involving the teeth and intra-oral areas surrounding the teeth are not covered.

Diagnosis and treatment of infertility is covered; **you pay** 20% of the cost of injectable prescription drugs for infertility therapy if there is prior authorization by a Plan doctor before therapy begins. **Artificial insemination** is covered; **you pay** 20% of the charges. Cost of donor sperm is not covered. Fertility drugs are covered. **Other assisted reproductive technology (ART) procedures** that enable a woman with otherwise untreatable infertility to become pregnant through other artificial procedures such as in vitro fertilization and embryo transfer are not covered.

Short term rehabilitation therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months. Speech therapy is limited to treatment of certain speech impairments of organic origin or to correct the effects of illness or injury. Occupation therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Habilitative care is speech, physical or occupational therapy which is provided for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and motor development. To be considered habilitative, significant functional improvement and measurable progress must be made toward achieving functional goals, within a predictable period of time toward an enrollee's maximum potential ability. The Plan will supplement and coordinate such services with similar benefits made available by other agencies, including the public school system. The determination of whether such measurable progress has been made is within the sole discretion of the Plan Medical Director, based on objective documentation.

Cardiac rehabilitation following a heart transplant, bypass surgery or myocardial infarction is provided for Phase I. Phase II is provided if the Plan determines it is medically necessary. Phase III is not covered. **You pay** nothing.

Reconstructive surgery will be provided to correct a condition which has resulted in a functional defect or that has resulted from injury or surgery that has produced a major affect on the member's appearance and the condition can reasonably be expected to be corrected by such surgery.

Hair prostheses when required because of hair loss due to alopecia areata are covered at 80% up to a maximum benefit of $350 per year; **you pay** 20% of the charges and all charges after the Plan pays $350.

Orthopedic devices, such as braces or foot orthotics, prosthetic devices, such as artificial limbs and external lenses following cataract surgery, and durable medical equipment, such as wheel chairs and hospital beds, are covered. **You pay** 20% of the charges. Rental of durable medical equipment is covered for up to one month while the enrollee's own equipment is being repaired. Durable medical equipment and supplies must be obtained from approved vendors.

Medical and Surgical Benefits *continued*

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically induced sterility, including related treatment for infertility
- Surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Blood and blood derivatives (no charge if replacement is arranged by member)
- Long term rehabilitation therapy
- Speech therapy services to correct development delays
- Genetic counseling and studies not required for diagnosis and treatment
- Artificial insemination for surrogate pregnancy
- Homemaker services
- Hearing aids
- Rental of durable medical equipment while enrollee's own equipment is being repaired, beyond one month rental of medically necessary equipment.
- Over-the-counter foot orthotics

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits limit when you are hospitalized under the care of a Plan doctor. **All necessary services are covered, including:**

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

High Option	Standard Option
You pay nothing.	**You pay** the first $200 per admission plus 20% of the next $3,500 of charges per calendar year. A separate copay applies to each person, including a newborn child.

Extended care

The Plan provides 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 a Plan doctor and approved by the Plan. **All necessary services are covered, including:**

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

High Option	Standard Option
You pay nothing.	**You pay** the first $200 per admission plus 20% of the next $3,500 of charges per calendar year.

Period of confinement means (1) continuous inpatient stay in a hospital or skilled nursing facility, or (2) a series of two or more inpatient 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 in that it is (a) within the same ascertainable diagnosis, or (b) within the scope of complications, or related conditions.

Hospital/Extended Care Benefits *continued*

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care; family counseling and respite and continuous care. Coverage for respite care is limited to five days. Periods of respite care and continuous care combined are limited to thirty days. These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

High Option	Standard Option
You pay nothing for part-time **and** intermittent care provided in the home, inpatient services, medications for pain and symptom management and durable medical equipment and continuous care. **You pay** 20% of charges for periods of respite care.	**You pay** a $10 copay per office or home visit by a doctor, nurse or other provider, including continuous care. For inpatient care, **you pay** the first $200 per admission plus 20% of the next $3,500 of charges. **You pay** 20% of charges for periods of respite care.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. Services are covered at 80% of charges. **You pay** 20%. Transfers between hospitals for treatment by Plan doctors are covered at 100% if initiated by a Plan doctor. **You pay** nothing for transfers.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure. This is limited to charges incurred by a covered person who: (1) is a child under age 5; (2) is severely disabled; or (3) has a medical condition and requires hospitalization or general anesthesia for dental care treatment. The Plan will cover the hospitalization and anesthesia charges (see High and Standard benefits on page 14), but not the cost of the professional dental services.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 18 for nonmedical Substance Abuse Benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Blood and blood derivatives (no charge if replacement is arranged by member)
- Custodial care, rest cures, domiciliary or convalescent care

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Emergency Benefits

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 the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergency Benefits *continued*

Emergencies within the Plan network

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (*e.g.,* the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan **must** be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time.

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

Plan pays…

Charges for emergency care services to the extent the services would have been covered if received from Plan providers.

High Option	Standard Option
All but $10 per visit in Plan urgent care clinics. All but $40 for authorized outpatient care in a Plan hospital. (This $40 emergency room copay is waived if the condition requiring outpatient care results in an authorized admission to the hospital within the next 24 hours.) Authorized inpatient hospital emergency care is covered in full; 80% of charges for ambulance service ordered or authorized by a Plan doctor.	All but $15 per visit in Plan urgent care clinics. All but $40 for authorized outpatient care in a Plan hospital. (This $40 emergency room copay is waived if the condition requiring outpatient care results in an authorized admission to the hospital within the next 24 hours.) 80% of charges for ambulance service ordered or authorized by a Plan doctor. Authorized inpatient hospital emergency care is covered after a $200 deductible, at 80% of the next $3,500 per calendar year and 100% thereafter of charges. 100% of physician charges for in-hospital care.

You pay…

High Option	Standard Option
$10 copayment per visit for care provided in Plan urgent care clinics. $40 per outpatient hospital visit. (This $40 emergency room copay is waived if the condition requiring out-patient care results in an authorized admission to the hospital within the next 24 hours.) 20% of charges for authorized ambulance service. Nothing for authorized inpatient hospital care. Any charges which are not a covered benefit of this Plan.	$15 copayment per visit for care provided in Plan urgent care clinics. $40 per outpatient hospital visit. (This $40 emergency room copay is waived if the condition requiring outpatient care results in an authorized admission to the hospital within the next 24 hours.) 20% of the charges for authorized ambulance services. For services in the hospital, the first $200 per admission plus 20% of the next $3,500 per calendar year.

Emergencies outside the Plan network

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. 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. To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Emergency Benefits *continued*

Plan pays…

Charges for emergency care services to the extent the services would have been covered if received from Plan providers.

High Option	Standard Option
80% of the first $2,500 and 100% thereafter of charges per calendar year for inpatient and outpatient hospital, medical and surgical benefits.	80% of the first $2,500 and 100% thereafter of charges per calendar year for doctor services in or outside of the hospital, outpatient hospital services and other covered non-hospital services. For inpatient services, after a $200 deductible per admission, 80% of the next $3,500 per calendar year and 100% thereafter of charges.

You pay…

High Option	Standard Option
20% of the first $2,500 of charges per calendar year; nothing thereafter for covered services.	20% of the first $2,500 per calendar year of charges for doctor services in or outside of the hospital, outpatient hospital services and other covered non-hospital services. For **inpatient** services, the first $200 per admission plus 20% of the next $3,500 of charges per calendar year.

What is covered

- Emergency care at a doctor's office or urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services if approved by the Plan
- Ambulance service if approved by the Plan
- Emergency dental care from non-Plan dentists; see page 20

What is not covered

- Elective care or nonemergency care
- Emergency care provided outside the Service Area if the need for care could have been foreseen before departing the Service Area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the Service Area

Filing claims for non-Plan providers

With your authorization, the Plan will pay emergency benefits directly to the providers of your emergency care upon receipt of their claims, submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. A payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. You may request reconsideration in accordance with the disputed claims procedure set forth on the inside back cover of this brochure.

Mental Conditions/Substance Abuse Benefits

Mental Conditions

The medical management of mental conditions will be covered under this Plan's medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits.

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

All necessary outpatient care from Plan doctors, consultants or other psychiatric personnel each calendar year

High Option	Standard Option
You pay a $10 copay per office visit.	**You pay** a $15 copay per office visit.

Inpatient care

All necessary hospitalization and inpatient psychiatric medical care each calendar year.

High Option	Standard Option
You pay nothing.	**You pay** first $200 per admission plus 20% of the next $3,500 of charges per calendar year.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance Abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition.

Outpatient care

All necessary outpatient care.

High Option	Standard Option
You pay a $10 copay per office visit.	**You pay** a $15 copay per office visit.

Inpatient care

Treatment in a substance abuse rehabilitation (intermediate care) program in an alcohol detoxification or rehabilitation center approved by the Plan. Inpatient services are limited to emergency care, detoxification and treatment planning.

High Option	Standard Option
You pay nothing.	**You pay** first $200 per admission plus 20% of the next $3,500 of charges per calendar year.

What is not covered

- Treatment that is not authorized by a Plan doctor.

Prescription Drug Benefits

What is covered

Prescription drugs must be prescribed by a Plan or referral doctor, obtained at a Plan pharmacy and dispensed in accordance with the Plan's formulary. **You pay** an $8 copay per prescription unit or refill for each 30 day supply or portion thereof. If you are requesting a brand name drug and there is a generic equivalent, the brand name drug will only be covered up to the charge that would apply to the generic drug, minus any required copayment. If your Plan doctor has indicated on the prescription that the brand name drug should be dispensed as written, the brand name drug will be covered in full, minus any required copayment

The Plan's formulary is a list of drugs chosen for coverage by the Plan's Pharmacy and Therapeutics (P&T) Committee based on a drug's safety, effectiveness and cost. The Plan's P&T Committee evaluates any needed changes to the formulary on a quarterly basis.

Non-formulary drugs will be covered when prescribed by a Plan doctor. It is the Plan doctor's responsibility to obtain authorization for non-formulary drugs before they are dispensed.

The Plan's formulary will be covered. Non-formulary drugs will be covered when prescribed by a Plan doctor. It is the prescribing doctor's responsibility to obtain authorization for non-formulary drugs before they are dispensed.

High Option	Standard Option
You pay up to an $8 copay per prescription unit or refill for each 30 day supply or portion thereof.	**You pay** up to a $10 copay per prescription unit or refill for each 30 day supply or portion thereof.

Covered medications and accessories include:

- Drugs for which a prescription is required by law and that are obtained at participating pharmacies
- Oral contraceptive drugs and contraceptive barrier devices; a single copay charge will apply for 3 cycles of oral contraceptive drugs and for each barrier device
- Insulin, with a copay charge applied to each vial
- Diabetic testing supplies
- Disposable needles and syringes needed to inject covered prescribed medication, including insulin
- Intravenous fluids and medications for home use
- Tobacco cessation products, as determined by the Plan, limited to a 60 consecutive day supply per calendar year. Benefits are limited to one product at a time, and no more than a 30 day supply will be covered and dispensed at a time.

Limited benefits

- Injectable and implantable contraceptive devices. **You pay** 20% of the charges.
- Growth hormones. **You pay** 20% of the charges.
- Injectable drugs for the treatment of infertility. **You pay** 20% of the charges.
- Special dietary treatment for phenylketonuria (PKU) is covered. **You pay** 20% of the charges.
- Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Contraceptive devices (except as listed above)
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance

Other Benefits

Dental care

What is covered (High Option)

The following preventive and diagnostic dental services are covered for all members when provided by participating Plan dentists. Benefit limitations are noted where they apply. **High Option members pay nothing** (no benefits are provided for preventive dental under the Standard Option).

- Routine dental examinations (per Plan dentist's recommendation)
- Teeth cleaning, prophylaxis or periodontal maintenance recall (limited to twice per 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 year)
- Full-mouth (panoramic) x-rays (limited to once every three years)

Accidental injury benefit

Services of Plan dentists necessary to promptly repair or replace sound natural teeth, limited to restorative services and supplies plus prescription and installation of necessary dental prosthetic items or devices. The need for these services must directly result from an accidental injury, not including injury from biting or chewing, occurring while the member is covered under the FEHB Program and treatment and repair must be completed within twelve months of the date of injury. **You pay** dental laboratory's actual charge for prescription dental prosthetic items and devices related to the accident plus any dental services rendered in connection with previously missing teeth or for teeth not injured in the accident.

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. After a $50 calendar year deductible, **you pay** 20% of the charges, up to a maximum Plan benefit of $300 per calendar year, and any charges thereafter.

What is not covered

Other dental services not shown as covered

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, eye refractions, including lens prescriptions are covered. **You pay** nothing.

What is not covered

- Corrective eyeglasses, frames and contact lenses
- Eye exercises
- Radial keratotomy

Non-FEHB Benefits Available to Plan Members

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 5, 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. Contact us at 883-5601 for information on the Medicare prepaid plan and the cost of that enrollment.

Benefits in this box are not part of the FEHB Contract.

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Member Services Department at 612/883-5000 or 1-800/883-2177 (hearing impaired individuals should call 1-612/883-5127) or you may write to the Plan at 8100 34th Avenue South, Minneapolis, MN 55440-1309.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing, within one year of the denial, to reconsider its denial before you request a review by OPM. OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan should state why you believe the denied claim for payment or service should have been paid or provided. Refer to specific benefit provisions in this brochure.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative and request an OPM review on your behalf and with your written consent. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review should state why you believe the Plan should have paid the denied claim. Refer to specific benefit provisions in this brochure. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (If the Plan failed to respond, provide instead (a) the date of your request to the Plan, or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, Explanation of Benefit forms, etc.); and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Retirement and Insurance Service, Office of Insurance Programs, Insurance Contracts Division IV, P.O. Box 436, Washington, DC 20044.

How to Obtain Benefits *continued*

No lawsuit may be brought to recover on a claim for this Plan's benefits until either you or, in the case of an assigned claim, your provider has exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement — If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How this Plan Changes January 1999

Do not rely on this page; it is not an official statement of benefits.

Program-wide changes

Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist.

A medical emergency is defined as 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 (see page 15).

The medical managment of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits.

Changes to this Plan

A habilitative care benefit has been added under Medical and Surgical Benefits. See page 13 for details

Rental of medically necessary durable medical equipment is covered, up to one month, while an enrollee's medical equipment is being repaired.

The Prescription Drug copay for the Standard Option Plan has changed to $10.

A tobacco cessation benefit has been added under Prescription Drug Services, up to a 60 day supply per calendar year.

Some frequency limitations have been added to the dental care section under Other Benefits. Teeth cleaning is limited to twice per year; bitewing x-rays are limited to once per year; and full-mouth x-rays are limited to once every three years.

Summary of Benefits for HealthPartners Classic - 1999

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated, subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure).

ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.

Benefits		High Option pays/provides	Page	Standard Option pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services with no dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	14	Comprehensive range of medical and surgical services with no dollar or day limit. Includes in-patient doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** $200 per admission plus 20% of the next $3,500 of charges per calendar year	14
	Extended Care	All necessary services for up to 180 days per period of confinement. **You pay** nothing	14	All necessary services for up to 180 days per period of confinement. **You pay** $200 per admission plus 20% of the next $3,500 of charges per calendar year	14
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions. **You pay** nothing	18	Diagnosis and treatment of acute psychiatric conditions. **You pay** $200 per admission plus 20% of the next $3,500 of charges days per calendar year.	18
	Substance Abuse	Each member is entitled to all necessary treatment for substance abuse programs. You pay nothing.	18	Each member is entitled to all necessary treatment for substance abuse programs. **You pay** first $200 per admission plus 20% of the next $3,500 of charges per calendar year	18
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** $10 per visit. **You pay** nothing for preventive care, including well baby care, periodic check ups and routine immunizations.	12	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** $15 per visit. **You pay** nothing for preventive care, including well baby care, periodic check ups and routine immunizations.	12
	Home Health Care	All necessary visits by nurses and health aides. **You pay** $10 per visit for physical therapy, occupational therapy, speech therapy, respiratory therapy and home health aide services; and nothing for all other services.	13	All necessary visits by nurses and health aides. **You pay** $15 per visit for physical therapy, occupational therapy, speech therapy, respiratory therapy and home health aide services; and nothing for all other services.	13
	Mental Conditions	All necessary outpatient visits. **You pay** $10 per visit	18	All necessary outpatient visits. **You pay** $15 per visit	18
	Substance Abuse	All necessary outpatient visits. **You pay** $10 per visit	18	All necessary outpatient visits. **You pay** $15 per visit	18
Emergency care		Charges for services and supplies required because of a medical emergency. **You pay** $10 at Plan medical centers; $40 per authorized outpatient Plan hospital visit; 20% of the first $2,500 of authorized charges at non-Plan facilities; 20% of authorized ambulance expense.	15-17	**You pay** $15 per visit at Plan medical centers; $40 per authorized outpatient Plan hospital visit. 20% of the first $2,500 of authorized charges at non-Plan facilities; 20% of authorized ambulance expense.	15-17
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at participating pharmacies. **You pay** up to $8 per prescription unit or refill	19	Drugs prescribed by a Plan doctor and obtained at participating pharmacies. **You pay** up to $10 per prescription unit or refill	19
Dental care		Accidental injury benefit and preventive dental care. You pay no copayment for preventive care or for services of Plan dentists for accidental injury. **You pay** dental laboratory charges for accidental injury	20	Accidental injury benefit. **You pay** dental laboratory charges	20
Vision care		Eye refractions, including lens prescriptions, **you pay** nothing	20	Eye refractions, including lens prescriptions, **you pay** nothing.	20
Out-of-pocket limit		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $3,000 per Self Only or $5,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%	8	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $3,000 per Self Only or $5,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%	8

1999 Rate Information for HealthPartners Classic

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 most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		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**
High Option Self Only	**531**	**$ 72.06**	**$ 26.23**	**$156.13**	**$ 56.83**	**$ 84.98**	**$ 13.31**
High Option Self and Family	**532**	**$160.39**	**$ 75.49**	**$347.51**	**$163.56**	**$183.29**	**$ 52.59**
Standard Option Self Only	**534**	**$ 62.38**	**$ 20.79**	**$135.15**	**$ 45.05**	**$ 73.81**	**$ 9.36**
Standard Option Self and Family	**535**	**$149.69**	**$ 49.90**	**$324.34**	**$108.11**	**$177.14**	**$ 22.45**