

A Health Maintenance Organization

Serving: Greater Minneapolis - St. Paul - St. Cloud - West Central Wisconsin

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

Enrollment in this Plan is limited; see page 5 for requirements.



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

Special Notice: This Plan has significantly reduced its service area. See page 4 for more information.

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

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**United States
Office of
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Management**



Table of Contents

	Page
Introduction	3
Plain language	3
How to use this brochure.....	3
Section 1. Health Maintenance Organizations	4
Section 2. How we change for 2000	4-5
Section 3. How to get benefits	5-7
Section 4. What to do if we deny your claim or request for service.....	7-8
Section 5. Benefits	9-17
Section 6. General exclusions – Things we don’t cover.....	18
Section 7. Limitations – Rules that affect your benefits	18-19
Section 8. FEHB facts.....	19-22
Inspector General Advisory: Stop Healthcare Fraud!	22
Summary of benefits	Inside back cover
Premiums	Back cover

Introduction

Group Health, Inc. dba HealthPartners Classic
8100 34th Avenue South
Minneapolis, Minnesota 55440

This brochure describes the benefits you can receive from HealthPartners Classic under its contract (CS1048) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on pages 4-5. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to HealthPartners Classic as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

- 1. Health Maintenance Organizations (HMO).** This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.
- 2. How we change for 2000.** If you are a current member and want to see how we have changed, read this section.
- 3. How to get benefits.** Make sure you read this section; it tells you how to get services and how we operate.
- 4. What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
- 5. Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
- 6. General exclusions – Things we don't cover.** Look here to see benefits that we will not provide.
- 7. Limitations – Rules that affect your benefits.** This section describes limits that can affect your benefits.
- 8. FEHB facts.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure.

When you receive emergency services 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

To keep your premiums as low as possible OPM has set a minimum copay of \$10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. See Section 3, How to get benefits, for more information.

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- The Plan has reduced its service area by no longer serving the following partial counties in Minnesota: **Crow Wing County**, including the townships of Crow Wing, Daggett, Brook, Fort Ripley, Long Lake, Maple Lake, Nokay Lake, Oak Lawn, Platte Lake and St Mathias; **Todd County**, including the townships and cities of Bruce, Burnhamville, Clarissa, Clotho, Fawn Lake, Gray Eagle, Hartford, Little Elk, Little Sauk, Long Prairie, Reynolods, Round Prairie, Turtle Creek, and West Union; **Douglas County**, including the townships and cities of Alexandria, Belleriver, Carlos, and Osakis; **Kandiyohi County**, including the townships and cities of Hawick, New London, and Regal; and **Pope County**, including the townships and cities of Glenwood, Sedan, Villard and Westport.
- Your share of the non-postal standard option premium will increase by 14% for Self Only and for Self and Family.

Your share of the non-postal high option premium will increase by 22.5% for Self Only or 19.7% for Self and Family.
- A mail order drug benefit has been added which provides a 90-day supply for two prescription drug copays (\$16 for the High Option plan and \$20 for the Standard Option plan).
- Orthognathic surgery coverage has been added under the oral and maxillofacial surgery benefit with 25% of charges coinsurance. Coverage for the treatment of temporomandibular joint (TMJ) has increased to include the related dental appliance. See page 10.
- Coverage for transplants has increased to remove certain limits for kidney/pancreas transplants and autologous bone marrow transplants for neuroblastoma. See page 9.

Section 2. How we change for 2000 *continued*

Changes to this Plan *continued*

- Benefits for the treatment of infertility does not include the cost of donor sperm or ova, or storage of donor sperm, ova or embryo. See page 10.
- Hospice care has been clarified to indicate that the five day limit for respite care applies per episode. The member must pay all charges thereafter. See page 12.
- Short-term rehabilitative therapy has been clarified to show that respiratory therapy is also covered along with physical, speech, and occupational and there is a \$10 copay per outpatient session for High Option and a \$15 copay per outpatient session for Standard Option. See page 10.
- Inpatient substance abuse care in an alcohol detoxification or rehabilitation center will no longer be limited to emergency care, detoxification and treatment planning.
- Durable medical equipment has been clarified to indicate that glucose monitors and insulin pumps are covered if deemed medically necessary. See page 11.
- The office visit copay for group therapy mental conditions visits have decreased from \$10 for high option and \$15 for standard option to \$5 for high option and \$7.50 for standard option. See page 15.
- Medically necessary care (as determined by the Plan Medical Director) for procedures, services and supplies related to sex transformations are covered in full.

Section 3. How to get benefits

What is this Plan's service area?

To enroll with us, 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, Hennepin, Morrison, Ramsey, Rice, Scott, Sherburne, Stearns, Washington and Wright.

The following partial county in Minnesota: Mille Lacs and Isanti.

The following counties in Wisconsin: 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. We will not pay for any other health care services.

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.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges).

After you pay \$3,000 in copayments or coinsurance for one family member, or \$5,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the calendar year. This is called a catastrophic limit.

Be sure to keep accurate records of your copayments and coinsurance, since you are responsible for informing us when you reach the limits.

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Section 3. How to get benefits *continued*

Who provides my health care?

Health Partners Classic is a group practice prepayment plan that allows members to 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.

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 612/883-5000 or 1-800/883-2177 (hearing impaired individuals should call 612/883-5127). If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist with the following exception: a woman may see a plan gynecologist associated with her clinic for her annual wellness exam without a referral.

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.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

What do I do if my 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.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

Section 3. How to get benefits *continued*

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care.

You should check with your Plan physician 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.

How do you decide if a service is experimental or investigational?

The plan 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, and its efficacy as compared with the standard means of treatment or diagnosis.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us at (612) 883-5000 or 1-800-883-2177 (hearing impaired individuals should call (612) 883-5127) and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division IV at (202) 606-0737 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Section 4. What to do if we deny your claim or request for service *continued*

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

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

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

What address should I send my disputed claim to?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division IV, P.O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. BENEFITS

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

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.

Standard Option

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 diabetes; kidney; liver transplants for biliary atresia in children, primary biliary 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, neuroblastoma, breast cancer, multiple myeloma, 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

Section 5. BENEFITS *continued*

Medical and Surgical Benefits

What is covered

continued

- 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.
- 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.
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, 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 *temporomandibular joint* (TMJ) pain dysfunction syndrome (including the related dental appliance) 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.

Orthognathic surgery is covered 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. Functional impairments include, but are not limited to, difficulties in chewing, breathing, or swallowing. **You pay** 25% of charges. Associated orthodontic services (pre or post operative) is not covered.

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 or ova, or cost of storage of donor sperm, ova or embryo, 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 rehabilitative therapy (physical, speech, respiratory 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. **You pay** a \$10 copay(High Option); or \$15 (Standard Option) per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin or to correct the effects of illness or injury. Occupational 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.

Section 5. BENEFITS *continued*

Medical and Surgical Benefits

Limited benefits

continued

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. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

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, breast prostheses, surgical bras and external lenses following cataract surgery, and durable medical equipment, such as wheel chairs and hospital beds, glucose monitors and insulin pumps deemed medically necessary 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. The Plan will determine whether an item is approved for purchase or rental. Durable medical equipment and supplies must be obtained from approved vendors.

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 medically necessary durable medical equipment while enrollee's own equipment is being repaired, that is beyond one month rental.
- 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

You pay nothing.

Standard Option

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.

Section 5. BENEFITS *continued*

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

You pay nothing.

Standard Option

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.

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 per episode; you pay all charges thereafter. 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

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.

Standard Option

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. **You pay** 20% of charges. 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 11), 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 15 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

Section 5. BENEFITS *continued*

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.

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

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.

Standard Option

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

\$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 outpatient 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.

Standard Option

\$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.

Section 5. BENEFITS *continued*

Emergency Benefits *continued*

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.

Emergencies outside the Plan network

Plan pays...

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

High Option

80% of the first \$2,500 and 100% thereafter of charges per calendar year for inpatient and outpatient hospital, medical and surgical benefits.

Standard Option

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

20% of the first \$2,500 of charges per calendar year; nothing thereafter for covered services.

Standard Option

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 17

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.

Section 5. BENEFITS *continued*

**Mental Conditions/
Substance Abuse Benefits****Mental Conditions****What is covered**

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.

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

You pay a \$10 copay per office visit and a \$5 copay per group therapy visit.

Standard Option

You pay a \$15 copay per office visit and a \$7.50 copay per group therapy visit.

Inpatient care

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

High Option

You pay nothing.

Standard Option

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

You pay a \$10 copay per office visit.

Standard Option

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.

High Option

You pay nothing.

Standard Option

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.

Section 5. BENEFITS *continued*

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. 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

You pay up to an \$8 copay per prescription unit or refill for each 30 day supply or portion thereof.

Standard Option

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 **or** 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 *are covered under medical and Surgical Benefits.*
- 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.

Mail order benefit

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 (800) 883-2177. This benefit does not apply to drugs covered under the "Limited benefits" shown below.

High Option

You pay a \$16 copay for each prescription unit or refill for each 90 day supply, or portion thereof.

Standard Option

You pay a \$20 copay for each prescription unit or refill for each 90 day supply, or portion thereof.

Limited benefits

- Injectable and implantable contraceptive drugs or devices (such as Depo Provera, Norplant, IUD's). **You pay** 20% of charges.
- Growth hormones. **You pay** 20% of charges.
- Injectable drugs for the treatment of infertility. **You pay** 20% of charges.
- Special dietary treatment for phenylketonuria (PKU) is covered. **You pay** 20% of 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

Section 5. BENEFITS *continued*

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, 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

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims procedure.

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 18, 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.

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 or condition.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Experimental or investigational procedures, treatments, drugs or devices;
- 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;
- Procedures, services, drugs and supplies related to sex transformations, **unless determined medically necessary by the Plan Medical Director;**
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 17.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

Section 7. Limitations – Rules that affect your benefits *continued*

When others are responsible for injuries	When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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. If you need more information, contact us for our subrogation procedures.
TRICARE	TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.
Workers' compensation	<p>We do not cover services that:</p> <ul style="list-style-type: none"> • You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide; • 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. <p>Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.</p>
Medicaid	We pay first if both Medicaid and this Plan cover you.
Other Government Agencies	We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Section 8. FEHB FACTS

You have a right to information about your HMO.	<p>OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.</p> <p>If you want specific information about us, call 612/883-5000 or 1-800/883-2177 (hearing impaired individuals should call 612/883-5127), or write to HealthPartners Member Services Department, 8100 34th Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.</p>
Where do I get information about enrolling in the FEHB Program?	<p>Your employing or retirement office can answer your questions, and give you a <i>Guide to Federal Employees Health Benefits Plans</i>, brochures for other plans and other materials you need to make an informed decision about:</p> <ul style="list-style-type: none"> • 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 • The next Open Season for enrollment. <p>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.</p>
When are my benefits and premiums effective?	The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

Section 8. FEHB FACTS *continued*

What happens when I 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, which is described later in this section.

What types of coverage are available for me and my 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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Are my medical and claims records 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 payment 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

Section 8. FEHB FACTS *continued*

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse 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 more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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.

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

Section 8. FEHB FACTS *continued*

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

How can I get a Certificate of Group Health Plan 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. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

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 at **612/883-5000 or 1-800-2177 (hearing impaired individuals should call 612/883-5127)** and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

U.S. Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street, NW, Room 6400

Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for HealthPartners Classic - 2000

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.....	11	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.....	11
Extended care	All necessary services for up to 180 days per period of confinement. You pay nothing.....	12	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...12	
Mental conditions	Diagnosis and treatment of acute psychiatric conditions. You pay nothing.....	15	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.15	
Substance abuse	Each member is entitled to all necessary treatment for substance abuse programs. You pay nothing.....	15	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.....15	
Outpatient care				
Home health 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. ...9		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.9	
Mental conditions	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.10		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.10	
Substance abuse	All necessary outpatient visits. You pay \$10 per visit.....	15	All necessary outpatient visits. You pay \$15 per visit.....15	
Emergency care	All necessary outpatient visits. You pay \$10 per visit.....	15	All necessary outpatient visits. You pay \$15 per visit.....15	
Prescription drugs	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.....13-14		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.....13-14	
Dental care	Drugs prescribed by a Plan doctor and obtained at participating pharmacies. You pay up to \$8 per prescription unit or refill (mail order benefit is two copays per 90-day supply).....	16	Drugs prescribed by a Plan doctor and obtained at participating pharmacies. You pay up to \$10 per prescription unit or refill (mail order benefit is two copays per 90-day supply).....	16
Vision 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.....	17	Accidental injury benefit. You pay dental laboratory charges.....	17
Out-of-pocket limit	Eye refractions, including lens prescriptions, you pay nothing.....	17	Eye refractions, including lens prescriptions, you pay nothing.....	17
	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%.....	5	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%.....	5

2000 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. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee, but not a member of a special postal employment class, refer to the category definitions in, "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2 to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		<u>Non-Postal Premium</u>				<u>Postal Premium A</u>		<u>Postal Premium B</u>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share

High Option Self Only	531	\$ 78.83	\$ 32.14	\$170.80	\$ 69.64	\$ 93.06	\$ 17.91	\$ 93.26	\$ 17.71
High Option Self and Family	532	\$175.97	\$ 90.33	\$381.27	\$195.71	\$207.74	\$ 58.56	\$201.02	\$ 65.28

Standard Option Self Only	534	\$ 71.14	\$ 23.71	\$154.13	\$ 51.38	\$ 84.18	\$ 10.67	\$ 84.18	\$ 10.67
Standard Option Self and Family	535	\$170.70	\$ 56.90	\$369.85	\$123.28	\$202.00	\$ 25.60	\$201.02	\$ 26.58