HealthPartners Primary Clinic Plan

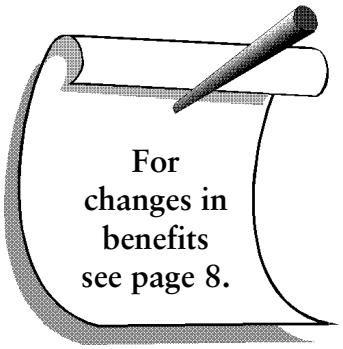
http://www.healthpartners.com
http://www.consumerchoice.com/fehb

HealthPartners®

2003

A Health Maintenance Organization

Serving: Minneapolis, St. Paul, St. Cloud, South Central, South Eastern and surrounding communities in Minnesota
West Central Wisconsin



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

HealthPartners has been awarded "Excellent" Accreditation for its commercial HMO, point-of-service and Medicare+Choice plans from the National Committee for Quality Assurance (NCQA). NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's health care.

Enrollment codes for this Plan:

HQ1 Self Only
HQ2 Self and Family

Authorized for distribution by the:

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

FEHB
Federal Employees
Health Benefits Program

RI 73-584

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction

This brochure describes the benefits of HealthPartners Primary Clinic Plan under our contract [CS 2874] with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This plan is underwritten by HealthPartners Inc. The address for HealthPartners Primary Clinic Plan administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means HealthPartners Primary Clinic Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at call 952/883-5000 or 1-800-883-2177 and explain the situation.
- If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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

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

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

How we pay providers

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

Who provides my health care?

We are a group practice prepayment plan offering health services at more than 700 medical, mental health and dental facilities across Minnesota and in western Wisconsin. HealthPartners Primary Clinic Plan medical providers include more than 4,000 primary care physicians and nearly 9,000 specialists.

The HealthPartners Primary Clinic Network is made up of "care networks" of clinics, physicians, hospitals and other health care professionals who work together to provide your care. Each care network establishes the access procedures a member must follow to receive benefits. Some care networks require a referral for some services. Others offer direct access to care network specialists. All care networks offer direct access to Ob/Gyn providers and mental health/chemical health, routine vision and urgent care networks.

Your Rights

OPM requires all FEHB Plans to provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

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

HealthPartners is Minnesota's only consumer-guided health plan. Our Board of Directors is composed of consumer-elected members. HealthPartners is a licensed HMO in the State of Minnesota.

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

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

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

If you want more information about us, call 952/883-5000 or 1-800-883-2177 (hearing impaired individuals should call 952/883-5127), or write to HealthPartners, P.O. Box 1309, Minneapolis, MN 55440-1309. You may also contact us by fax at 952/883-5666 or visit our website at www.healthpartners.com.

Service Area

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

The following counties in Minnesota:

Anoka, Benton, Carver, Chisago, Dakota, Dodge, Fillmore, Goodhue, Hennepin, Houston, Isanti, LeSueur, Olmsted, McLeod, Meeker, Mill Lacs, Morrison, Ramsey, Rice, Scott, Sherburne, Stearns, Steele, Wabasha, Washington, Winona, and Wright.

The following counties in Wisconsin:

Buffalo, Pepin, Pierce, Polk and St. Croix

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

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2003

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

Program-wide changes

- All references to "out-of-pocket maximum" have been changed to "catastrophic protection out-of-pocket maximum."
- We changed the address for sending disputed claims to OPM. (Section 8)
- Section 9 has been revised in the Medicare, TRICARE, and Medicaid paragraphs to reflect changes authorized by new OPM suspension regulations.
- A Notice of the Office of Personnel Management's Privacy is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program Enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- The copayment for office visits (other than preventive care visits), including visits to Plan urgent care centers, increased from $15 to $20.
- The copayment for mental health and substance abuse group therapy office visits increased from $7.50 to $10.
- You will pay a $200 copayment for each inpatient hospital admission, including extended care/skilled nursing care facilities.
- Copayments for prescription drugs have increased:
  - The copay for formulary drugs increased from $10 to $12 for a 30-day supply.
  - The copay for nonformulary drugs increased from $20 to $24 for a 30-day supply.
  - The copay for formulary drugs increased from $20 to $24 for a 90-day supply purchased through our mail order service.
  - The copay for nonformulary drugs increased from $40 to $48 for a 90-day supply purchased through our mail order service.
  - *For your convenience,* you may also order insulin, infertility drugs and growth hormones through the mail order service without a discounted benefit.
- You will pay 20% of the charges for ambulance transportation between network hospitals when transfer is initiated by the Plan physician.
- "Testing and treatment of sexually transmitted diseases and testing for HIV and HIV-related conditions provided by a Plan or non-Plan provider" is covered under Diagnostic and Treatment Services. You pay a $20 office visit copayment

Section 3. How you get care

Identification cards

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

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

Where you get covered care

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

- **Plan providers**

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

HealthPartners Primary Clinic Plan is a group practice prepayment plan that allows members to receive health services at more than 700 medical, mental health and dental facilities. HealthPartners Primary Clinic Plan medical providers include more than 4,000 primary care doctors and nearly 9,000 specialists.

When you enroll in HealthPartners Primary Clinic Plan, you select a primary care clinic. You'll receive most of your care from that clinic. Each covered person in a family may select a different primary care clinic and may change clinic selections monthly.

We list Plan providers in the provider directory, which we update periodically. For the most up-to-date information, visit www.consumerchoice.com/fehb., where information is updated weekly.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website: www.consumerchoice.com/fehb.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member should choose a primary care physician at the primary care clinic you enroll in. This decision is important since your primary care physician provides or arranges for most of your health care. For help selecting a primary care physician, call your clinic.

- **Primary care**

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

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

* Although Obstetrics/Gynecology (Ob/Gyn) is not considered primary care, each care network allows members direct access – no referral required – to the Ob/Gyn providers associated with their care network.

- **Specialty care**

In most cases, your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral.

However, some clinics allow you to self-refer to certain specialists. These specialists are listed in the directory and on www.consumerchoice.com/fehb with the note "No Referral Required."

No matter which primary care clinic you use, all members have direct access – no referral required – to the following specialized care:

- Ob/Gyn providers associated with your care network
- Mental Health/Chemical Health Network
- Vision Care Network
- Urgent Care Network

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 120 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 120 days.

- **Hospital care**

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

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

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

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

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

Services requiring our prior approval

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

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

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

The complete list, along with the criteria we use to review authorization requests, is available on www.healthpartners.com. or by calling HealthPartners Member Services at 952/883-5000 or 1-800-883-2177 (hearing impaired individuals should call 952/883-5127).

Your Plan physician is responsible for obtaining prior authorization.

Section 4. Your costs for covered services

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

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician you pay a copayment of $20 per office visit, and when you go in the hospital you pay $200 per admission.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- There is no deductible for services except dental care needed as the result of an accidental injury, as described in Section 5(h).

  We have a separate $50 annual deductible for emergency dental services for accidental injury when care is provided by a non-Plan dentist. Copayments or coinsurance for any other service do not count toward this deductible.

NOTE: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: In our Plan, you pay 20% of our allowance for infertility services and durable medical equipment.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

After your copayments and/or coinsurance total $3,000 per person or $5,000 per family in any calendar year, you do not have to pay any more for covered services. Be sure to keep accurate records of your copayments and/or coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 57 for a benefits summary.)

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

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered* services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion • Testing and treatment of sexually transmitted diseases and testing for HIV and HIV-related conditions provided by a Plan or non-Plan provider	$20 per office visit
• During a hospital stay • In a skilled nursing facility	Nothing
Not covered: Genetic counseling and studies not required for diagnosis and treatment.	*All charges*
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Preventive care, adult	You pay

Routine health exams, periodic health assessments, and cancer screenings, such as:
• Total Blood Cholesterol – once every three years
• Colorectal Cancer Screening, including
  • Fecal occult blood test
  • Sigmoidoscopy, screening – every five years starting at age 50
• Prostate Specific Antigen (PSA test) – one annually for men age 40 and older
• Routine pap test
• Routine hearing and eye exams
• Routine mammogram – covered for women age 35 and older, as follows:
  • From age 35 through 39, one during this five year period
  • From age 40 through 64, one every calendar year
  • At age 65 and older, one every two consecutive calendar years
• Adult immunizations
NOTE: The above frequency guidelines are minimum benefits offered under the Plan. These services may be provided more frequently if they are medically necessary.
	Nothing

Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Preventive care, children	
• Child health supervision services, including well-child care charges for routine examinations and care (through age 22). • Childhood immunizations recommended by the American Academy of Pediatrics • Routine hearing and eye exams.	Nothing

Maternity care	You pay
• Prenatal care • Postnatal care	Nothing
• Delivery NOTE: Here are some things to keep in mind: • You do not need to prior authorize your normal delivery; see page 12 or other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury.	*See Hospital benefits (Section 5c) and Surgery benefits (Section 5b)*
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
A range of voluntary family planning services, such as: • Family planning services provided by a Plan provider or non-Plan provider	Nothing
• Voluntary sterilization (see Surgical procedures Section 5 (b))	$20 per office visit $200 per admission for inpatient hospital Nothing for outpatient hospital
• Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) NOTE: We cover oral contraceptives and diaphragms under the prescription drug benefit.	20% of charges
Not covered: Reversal of voluntary surgical sterilization, genetic counseling,	*All charges*

Infertility services	You pay

Diagnosis and treatment of infertility, such as:
• Artificial insemination:
  • *intravaginal insemination (IVI)*
  • *intracervical insemination (ICI)*
  • *intrauterine insemination (IUI)*
• Fertility drugs
NOTE: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. We cover the diagnosis of infertility services provided by a Plan or non-Plan provider.
	20% of charges

Not covered:
• *Assisted reproductive technology (ART) procedures, such as:*
  • *in vitro fertilization*
  • *embryo transfer, gamete GIFT and zygote ZIFT*
• *Services and supplies related to excluded ART procedures*
• *Cost of donor sperm or ova*
• *Cost of storage of donor sperm, ova or embryo*
• *Treatment of infertility after reversal of sterilization*
• *Artificial insemination for surrogate pregnancy*
	All charges

Allergy care	
Testing and treatment	$20 per office visit
Allergy injection and serum	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy NOTE: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 19. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy	$20 per office visit $200 per admission for inpatient hospital Nothing for outpatient hospital
• Blood and blood plasma (unless replaced) and blood derivatives for the treatment of blood disorders	Nothing
• Growth hormone therapy (GHT) NOTE: Growth hormone is covered under the prescription drug benefit. See *Services requiring our prior approval* in Section 3.	20% of charges
Not covered: Growth hormones which are not for growth hormone deficiency or chronic renal insufficiency.	*All charges*

Physical and occupational therapies	You pay

• Two months per condition per year for the services of each of the following:
  • qualified physical therapists;
  • occupational therapists.
  NOTE: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. You must achieve significant functional improvement, within a predictable period of time (generally within a period of two months), toward your maximum potential ability to perform functional daily living activities.
• Habilitative care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and motor development.
  NOTE: To be considered habilitative, significant functional improvement and measurable progress must be made toward achieving functional goals and your maximum potential ability, within a predictable period of time. We will supplement and coordinate such services with similar benefits made available by other agencies, including the public school system. Our Plan Medical Director will determine whether measurable progress has been made based on objective documentation.
	$20 per office visit
	$200 per admission for inpatient hospital
	Nothing for outpatient hospital

• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for Phase I. Phase II is provided if we determine it is medically necessary. Phase III is not covered.	$20 per office visit $200 per admission for inpatient hospital Nothing for outpatient hospital
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*

Speech therapy	You pay
• 2 months or 60 visits per condition per year NOTE: We only cover therapy to restore speech when there has been a total or partial loss of speech due to illness or injury. You must achieve significant functional improvement, within a predictable period of time, toward your maximum potential ability to perform functional daily living activities. • Speech therapy for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech development. NOTE: To be considered habilitative, significant functional improvement and measurable progress must be made toward achieving functional goals and your maximum potential ability, within a predictable period of time. We will supplement and coordinate such services with similar benefits made available by other agencies, including the public school system. Our Plan Medical Director will determine whether measurable progress has been made based on objective documentation.	$20 per office visit $200 per admission for inpatient hospital Nothing for outpatient hospital
Not covered: • *Long term rehabilitative therapy*	*All charges*
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 NOTE: See Preventive care, adult; Preventive care, children	Nothing
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• Eye exam to determine the need for vision correction • Annual eye refractions NOTE: See Preventive care, adult; Preventive care, children	Nothing
• Diagnosis and treatment of illness and injury to the eye	$20 per office visit
• Initial evaluation, lenses and fitting for contact or eyeglass lenses if medically necessary for the post-surgical treatment of cataracts or for the treatment of aphakia or keratoconous	$20 per office visit *All charges for lens replacement beyond the initial pair*
Not covered: • *Eyeglasses or contact lenses and, except as described above* • *Eye exercises* • *Radial keratotomy and other refractive surgery*	*All charges*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$20 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
We cover the following: • Orthopedic devices, such as braces and foot orthotics • Prosthetic devices, such as artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. NOTE: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Orthopedic and corrective shoes when approved by this Plan based on our criteria	20% of charges
• Wigs required due to hair loss caused by alopetia areata	20% of charges, and all charges beyond the $350 calendar year limit
Not covered: • *Over-the-counter foot orthotics* • *Replacement or repair of any covered items if they are damaged or destroyed by member misuse, abuse or carelessness; lost; or stolen* • *Duplicate or similar items* • *Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation* • *Other equipment and supplies, including but not limited to assistive devices, that we determine are not eligible for coverage*	*All charges*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors • Insulin pumps • Diabetic supplies	20% of charges
Not covered: • *Replacement or repair of any covered items if they are damaged or destroyed by member misuse, abuse or carelessness; lost; or stolen* • *Duplicate or similar items* • *Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation* • *Household equipment, such as exercise cycles, air purifiers, water purifiers, air conditioners, non-allergenic pillows, mattresses or water beds* • *Household fixtures, such as escalators or elevators, ramps, swimming pools or saunas* • *Modifications to the home, such as wiring, plumbing or charges to install equipment* • *Vehicle, car or van modifications, such as hand brakes, hydraulic lifts and car carriers* • *Rental of medically necessary durable medical equipment while your own equipment is being repaired, that is beyond one month rental* • *Other equipment and supplies, including but not limited to assistive devices, that we determine are not eligible for coverage*	*All charges*

Home health services	You pay
We cover home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or home health aide, as shown below:	
• Physical therapy, occupational therapy, speech therapy, respiratory therapy and home health aide services	$20 per visit
• TPN/intravenous therapy, skilled nursing services, prenatal and postnatal services, child health services and phototherapy	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	
Chiropractic services for rehabilitative care, provided to diagnose and treat acute neuromusculo-skeletal conditions, limited to: • Manipulation of the spine and extremities • Adjunctive procedures such as massage therapy, ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application, when they are performed in conjunction with other treatment by a chiropractor, are part of a prescribed treatment plan and are not billed separately	$20 per office visit
Not covered: • *Naturopathic services* • *Hypnotherapy*	*All charges*

Alternative treatments	You pay

We cover the following services:
• Acupuncture – by a certified Plan acupuncturist for:
  • anesthesia
  • pain management
  • chemical dependency
  • headaches
  • nausea
• Biofeedback for:
  • incontinence
  • headaches
  • musculo-skeletal spasms which do not respond to other treatments
  • mental/nervous disorders
  • neurological retraining
	$20 per office visit

Not covered: • *Naturopathic services* • *Hypnotherapy*	*All charges*
Educational classes and programs	
We cover education for preventive services and smoking cessation	Nothing
We cover education for the management of chronic health problems (such as diabetes)	$20 per office visit/session

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services described in this section are for the charges billed by a physician or other health care professional for your surgical care. The amount that you pay for these services depends on where the services are provided and follow the benefits described in Section 5 (a) and (c), unless otherwise specified below.
- YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR SOME SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures, including normal pre- and post-operative care by the surgeon • Treatment of fractures, including casting • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and Prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns NOTE: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$20 per office visit $200 per admission for inpatient hospital Nothing for outpatient hospital
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges*

Reconstructive surgery	You pay

• Surgery to correct a functional defect
• Surgery to correct a condition caused by injury or illness if:
  • the condition produced a major effect on the member's appearance and
  • the condition can reasonably be expected to be corrected by such surgery
• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; port wine stains; webbed fingers; and webbed toes.
NOTE: Port wine stains do not have to result in a functional defect to be covered.
• All stages of breast reconstruction surgery following a mastectomy, such as:
  • surgery to produce a symmetrical appearance on the other breast;
  • treatment of any physical complications, such as lymphedemas;
  • breast prostheses and surgical bras and replacements (see Prosthetic devices)
NOTE: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
	$20 per office visit
	$200 per admission for inpatient hospital
	Nothing for outpatient hospital

Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of* • *accidental injury* • *Surgeries related to sex transformation, unless determined medically necessary by the Plan Medical Director*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate (limited to dependent children to age 18); • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures, including non-dental treatment of temporomandibular joint dysfunction (TMJ).	$20 per office visit $200 per admission for inpatient hospital Nothing for outpatient hospital
• Orthognathic surgery for the treatment of a skeletal malocclusion when a functional occlusion cannot be achieved through non-surgical treatment alone and a demonstrable functional impairment exists.	25% of charges
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Orthodontic services (pre or post operative) associated with orthognathic surgery.*	*All charges*

Organ/tissue transplants	You pay
Transplant services are covered at our designated centers of excellence for transplants and are limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas for diabetes • Liver • Lung: Single – Double, for primary pulmonary hypertension, Eisenmenger's syndrome, end stage pulmonary fibrosis, alpha 1 antitrypsin disease, cystic fibrosis and emphysema • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; Hodgkin's lymphoma; non-Hodgkin's lymphoma; Burkitt's lymphoma; neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Allogenic (donor) bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for acute myelogenous leukemia; acute lymphotytic leukemia; chronic myelogenouis leukemia; severe combined immunodeficiency disease; Wiscott-Aldrich syndrome; and aplastic anemia • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. NOTE: We cover related medical and hospital expenses of the donor when we cover the recipient.	$200 per admission
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient) • Skilled nursing facility	$200 per admission
Professional services provided in – • Ambulatory surgical center • Hospital outpatient department	Nothing
Professional services provided in – • Doctor's office	$20 per office visit

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care and any costs associated with the professional charge (i.e., physicians, etc.) which are described in Sections 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood and blood plasma (unless replaced) and blood derivatives • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$200 per admission
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma (unless replaced) and blood derivatives • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Extended care benefits/skilled nursing care facility benefits	
We cover a comprehensive range of benefits for up to 180 days per period of confinement when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by your Plan doctor and prior authorized by this Plan. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, services and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your Plan doctor. Period of confinement means (1) continuous stay in a hospital or skilled nursing facility, or (2) a series of two or more stays in a hospital or skilled nursing facility for the same condition in which the end of each inpatient stay is separated from the beginning of the next one by less than 90 days. Same condition means illness or injury related to a former illness or injury that is (1) within the same ascertainable diagnosis, or (2) within the scope of complications, or related conditions.	$200 per admission
Not covered: Custodial care	*All charges*

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

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

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

Emergencies outside our service area: You must notify us within two days of admittance to an out-of-network hospital, or as soon as reasonably possible under the circumstances. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible. Follow-up care recommended by non-Plan providers must be approved by this Plan or provided by our providers.

Benefit Description	You pay
Emergency within our service area	
• Emergency and urgently needed care at a doctor's office • Emergency and urgently needed care at an urgent care center	$20 per office visit
• Emergency and urgently needed care as an outpatient at a hospital, including doctors' services NOTE: Copay waived if admitted to the hospital for the same condition within 24 hours	$50 per visit
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency and urgently needed care at a doctor's office • Emergency and urgently needed care at an urgent care center • Emergency and urgently needed care as an outpatient at a hospital, including doctors' services • Emergency and urgently needed care as an inpatient at a hospital, including doctors' services	20% of the first $2,500 of charges per calendar year
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	20% of charges

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

IMPORTANT

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **You do not need a referral** from your primary care physician to obtain mental health or substance abuse services. You must use a mental health or substance abuse provider that is in our Plan network. We list the mental health and substance abuse providers in our provider directory and on our website at www.consumerchoice.com/febh. If you have questions or need a provider directory, call HealthPartners Member Services Department at 952/883-5000 or 1-800-883-2177 (hearing impaired individuals should call 952/883-5127).
- **CERTAIN SERVICES MUST BE PRE-AUTHORIZED.** Your Plan physician is responsible for obtaining prior authorization.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. NOTE: Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or by providers such as psychiatrists, psychologists, or clinical social workers • Medication management • Overnight stay at a contracted organization if you are actively involved in an affiliated licensed chemical dependency day treatment program for treatment of alcohol or drug abuse.	$20 per visit
• Group therapy	$10 per office visit
• Diagnostic tests	Nothing

• Services provided by a hospital or other facility
• Services in approved alternative care settings such as:
  • Residential treatment
  • Partial hospitalization or full-day hospitalization for mental health services
	$200 per admission

Not covered: Services we have not approved. *NOTE: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Prior authorization	You do not need a referral from your primary care physician to obtain mental or substance abuse services. You must use a mental health or substance abuse provider that is in our Plan network. We list the mental health and substance abuse providers in our provider directory and on our website at www.consumerchoice.com/febh. If you have questions or need a provider directory, call HealthPartners Member Services Department at 952/883-5000 or 1-800-883-2177 (hearing impaired individuals should call 952/883-5127). Some therapies require the approval of a treatment plan, which your provider will submit for you.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A Plan physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy or by mail.
- **We cover formulary and non-formulary drugs.** Formulary drugs are a preferred list of drugs that we selected to meet patient needs at a lower cost.
- **These are the dispensing limitations.** Unless otherwise specified in this section, you may receive up to a 30-day supply per prescription. No more than a 90-day supply will be covered and dispensed at a time. If a copayment is required, you must pay one copayment for each 30-day supply, or portion thereof, or for each manufacturer's pre-packaged dispensing unit (but not less than your physicians' recommendation of a 30-day supply), except as follows:
  - For insulin a copayment will apply per vial or box of insulin cartridges.
  - For contraceptive barrier devices, a copayment will apply per device.
  - For mail order drugs, see benefit described below.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifies "Dispense as Written."
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.
- **If you request a refill too soon** after the last one was filled, it may not be filled at that time. It may require up to 14 days to get mail order prescriptions filled, so this service is best for maintenance drugs, not for drugs you need immediately or for drugs you are taking on a short-term basis. Federal or state regulations may prevent us from filling certain prescriptions through our mail order service, such as laws which prohibit us from sending narcotic drugs across state lines.
- **When you have to file a claim.** You do not need to file a claim for drugs obtained at a network pharmacy or through our mail order service. You would need to file a claim for prescription drugs covered as part of an out-of-area emergency, if you did not get them at a network pharmacy. See Section 7 for instructions on filing a claim.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase • Insulin, with a copay applied per vial • Diabetic testing supplies (see Glucose Monitors under Durable Medical Equipment) • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Limited Benefits on next page) • Oral contraceptive drugs and contraceptive barrier devices, a single copay charge will apply for 1 cycle of oral contraceptive drugs or for each barrier device • Tobacco cessation products, as determined by this Plan, limited to a 180-day supply per calendar year. Benefits will be limited to one product at a time, and no more than a 30-day supply will be covered and dispensed at a time.	$12 copay for formulary drugs $24 copay for non-formulary drugs The copay applies per 30-day supply, or portion thereof, or for one manufacturer's pre-packaged dispensing units, if applicable.
Mail order benefits	
You may also get outpatient prescription drugs which can be self-administered through HealthPartners mail order service. For information on how to obtain drugs through HealthPartners mail order service, please call 952/833-0497 or 1-800-356-6656. This benefit does not apply to drugs listed under Limited Benefits on the following page.	$24 copay for formulary drugs $48 copay for non-formulary drugs The copay applies per 90-day supply, or portion thereof, or for three manufacturer's pre-packaged dispensing units, if applicable. For your convenience, you may also order insulin, infertility drugs and growth hormones through the mail order service without a discounted benefit.

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

Section 5 (g). Special features

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

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- There is a $50 calendar year deductible for emergency accidental dental services provided by non-Plan dentists.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Dental benefits	
We cover the preventive and diagnostic dental services shown below for all members when provided by Plan dentists. Benefit limits are noted where they apply. • Routine dental examinations (per Plan dentist's recommendation); • Teeth cleaning, prophylaxis or periodontal maintenance recall (limited to twice per 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); and • Full mouth (panoramic) x-rays (limited to once every three calendar years).	Nothing
Not covered: Other dental services not shown as covered.	*All charges*
Accidental injury benefit	
We cover restorative services and supplies provided by Plan dentists necessary to promptly repair or replace sound, natural, unrestored teeth, including the cost and installation of necessary prescription dental prosthetic items or devices. The need for these services must directly result from an accidental injury, not including injury from biting or chewing. Coverage is limited to the initial treatment (or course of treatment) and/or restoration. Only services provided within 24 months from the date treatment or restoration was initiated are covered.	Nothing
Emergency dental services for accidental injury, as described above, are covered when they are provided by non-Plan dentists if the services require immediate treatment.	$50 calendar year deductible, then 20% of the charges, up to a maximum benefit of $300 per calendar year, and any charges thereafter
Not covered: Other dental services not shown as covered.	*All charges*

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations unless determined medically necessary by the Plan Medical Director; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

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

Medical, hospital and drug benefits

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

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

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

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

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Member Services, P.O. Box 1309, Minneapolis, MN 55440-1309; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Health Benefits Contracts Division 2, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. NOTE: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

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

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

- **The Original Medicare Plan**

(Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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

Claims process when you have the Original Medicare Plan -You probably will never have to file a claim form when you have both our plan and the Original Medicare Plan. When we are the primary payer, we process the claim first. When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 952/883-5000 or 1-800/883-2177 (hearing impaired individuals should call 952/883-5127.

We do not waive any costs when you have the Original Medicare Plan.

Please see the Primary Payer Chart on the following page.

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

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

- **Medicare managed care plan**

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

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

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

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

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium (OPM does not contribute to your Medicare managed care plan premium). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

If you do not enroll in Medicare Part A or B

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

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Coinsurance

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

Copayment

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

Covered services

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

Deductible

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

Experimental or investigational services

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

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

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

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

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

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

Us/We

Us and we refer to HealthPartners Primary Clinic Plan.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the option of the Blue Cross and Blue Shield Service Benefit Plan that provides the lower level of coverage;
- if you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- if you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact you employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

- **Temporary continuation of coverage (TCC)**

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

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

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

- **Converting to individual coverage**

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

Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);

- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

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

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans. For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available!

Open Season

The Federal Long Term Care Insurance Program's open season for enrollment ends on December 31, 2002. If you're a Federal employee, this is the chance for you and your spouse to apply by answering only a few questions about your health.

You Can Also Apply Later

You and your qualified relatives can still apply for coverage after open season ends. The difference for employees and their spouses is that they won't have the advantage of open season's abbreviated underwriting, so they'll have to answer more health-related questions. For annuitants and other qualified relatives, there's no difference in the underwriting requirements during and after the open season.

FEHB Doesn't Cover It

It's important to keep in mind that neither your FEHB plan nor Medicare covers the cost of long term care. Also called "custodial care," it's care you receive when you need help performing activities of daily living -- such as bathing or dressing yourself. This need can strike any one at any age and the cost of care can be substantial.

It's Not Too Late!

It's not too late to protect yourself against the high cost of long term care by applying for the Federal Long Term Care Insurance Program. Don't delay -- if you apply during open season, your premiums will be based on your age as of July 1, 2002. After open season, your premiums are based on your age at the time your application for enrollment is received by LTC Partners.

Find Out More

Call 1-800-LTC-FEDS (1-800-582-3337) or visit www.ltcfeds.com to get more information and to request an application.

.

Index

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

Notes

Notes

Notes

Summary of benefits for HealthPartners Primary Clinic Plan – 2003

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

Benefits	You Pay	Page
Medical services provided by physicians:		15
• Diagnostic and treatment services provided in the office	• $20 per office visit	
Services provided by a hospital:		
• Inpatient	• $200 per admission	31
• Outpatient	• $20 per office visit	32
Emergency benefits:		
• In-area	• $50 Emergency Room visit; $20 Urgent Care Center visit	35
• Out-of-area	• 20% of the first $2,500; nothing thereafter	35
Mental health and substance abuse treatment	Regular cost sharing	36
Prescription drugs		
• Retail pharmacy (generally a 30-day supply)	• $12 copay for formulary drugs**;** $24 copay for non-formulary drugs	39
• Mail order service (generally a 90-day supply)	• $24 copay for formulary drugs**;** $48 copay for non-formulary drugs	39
Dental Care		
• Preventive dental	• Nothing	42
• Accidental injury	• Nothing, if care is provided by Plan dentist	
Vision Care	Nothing for preventive care	16
Special features: CareLine℠ service; BabyLine℠ service; Partners for Better Health® Phone Line; Special phone lines for deaf and hearing impaired		41
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	$3,000 /Self Only or $5,000 /Family per calendar year.	13

2003 Rate Information for HealthPartners Primary Clinic Plan

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

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

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

Type of Enrollment	Code	*Non-Postal Premium*				*Postal Premium*	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Minneapolis, St. Paul, St. Cloud and surrounding communities in Minnesota West Central Wisconsin							
Self Only	**HQ1**	**$109.30**	**$ 93.75**	**$236.82**	**$203.12**	**$129.03**	**$ 74.02**
Self & Family	**HQ2**	**$249.62**	**$237.69**	**$540.84**	**$515.00**	**$294.70**	**$192.61**