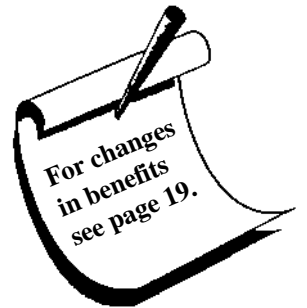




This plan has full accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.

A Health Maintenance Organization



**Serving: Minneapolis - St. Paul - St. Cloud area;
South Central Minnesota; Northwestern Minnesota;
Eastern North Dakota; West Central Wisconsin**

**Enrollment Code: HQ1 Self Only
HQ2 Self and Family**

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

All of the following counties in **Minnesota:** Anoka, Benton, Blue Earth, Brown, Carver, Chisago, Clay, Clearwater, Cottonwood, Dakota, Faribault, Goodhue, Hennepin, Isanti, Jackson, Le Sueur, McLeod, Martin, Meeker, Morrison, Murray, Nicollet, Nobles, Ramsey, Rice, Scott, Sherburne, Sibley, Stearns, Wabasha, Waseca, Washington, Watonwan, Wilkin and Wright.

The following partial counties in **Minnesota:** Becker, Beltrami, Cass, Crow Wing, Dodge, Douglas, Freeborn, Hubbard, Kandiyohi, Mahnomon, Mille Lacs, Mower, Norman, Olmsted, Otter Tail, Polk, Pope, Red Lake, Renville, Todd, Traverse and Wadena.

All of the following counties in **North Dakota:** Cass and Traill.

The following partial counties in **North Dakota:** Barnes, Dickey, Griggs, Kidder, LaMoure, Logan, Ransom, Richland, Steele and Stutsman.

All of the following counties in **Wisconsin:** Buffalo, Pepin, Polk and St. Croix.

(See pages 21-22 for complete list of service and enrollment area zip codes.)

Authorized for distribution by the:



**United States
Office of
Personnel
Management**



HealthPartners Health Plan

HealthPartners, Inc., 8100 34th Avenue South, Minneapolis, MN 55440 has entered into a contract (CS 2649) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called HealthPartners Health Plan or the Plan.

This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. A person enrolled in the Plan is entitled to the benefits stated in this brochure. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1997, and are shown on the inside back cover of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation —sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 612/399-2000 or 1-800/245-0655 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

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

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

General Information

Confidentiality

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

If you are a new member

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

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

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

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program except as stated in any cosmetic surgery or dental benefits description in this brochure.

General Information *continued*

If you are hospitalized

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

Your responsibility

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

Things to keep in mind

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

General Information *continued*

Things to keep in mind

continued

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

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

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

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

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

Coverage after enrollment ends

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

Former spouse coverage

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

Temporary continuation of coverage (TCC)

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

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

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

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

General Information *continued*

Notification and election requirements

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

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

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

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

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

Conversion to individual coverage

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

Facts about this Plan

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

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

Facts about this Plan *continued*

Who provides care to Plan members?

Member of the Plan receive health services through 250 medical clinics and 90 contracting hospitals throughout the Twin Cities and surrounding areas including St. Cloud, south central Minnesota, northwestern Minnesota, eastern North Dakota and western Wisconsin. HealthPartners Health Plan medical providers include 1,750 primary care doctors and over 2,500 community specialists to whom patients are referred. Members may choose any medical center in the HealthPartners Health Plan network for their primary care. Each covered person in a family may select a different medical center.

Role of a primary care doctor

The Plan's medical centers are of two types: those that are operated by the Plan and staffed by Plan employees (staff model clinics); and those with which the Plan has a contract for the provision of comprehensive health care (affiliated clinic). The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialist, generally are obtained. Plan members must obtain all of their medical care, including emergency care when possible, in the Plan facilities. Members are encouraged to select a primary care doctor (generally a pediatrician, an internist or a family practice doctor) who will provide most of their medical care and refer them to other medical specialists when necessary. In affiliated clinics, with which the Plan contracts, the member's primary care doctor must authorize and refer all care obtained through doctors and hospitals with which the Plan has arrangements. In staff model clinics, where the Plan's staff doctors practice, members may make appointments directly in the departments of obstetrics and gynecology, ophthalmology eye specialist), mental health and chemical health without a referral from their primary care doctor.

Choosing your doctor

The locations and telephone numbers of all medical centers are provided in a separate directory. Directories are provided to all enrollees at the time of enrollment or upon request by calling the Customer Service Department at 612-399-2000 or 1-800/245-0655 (hearing impaired individual should call 1-800/443-0156 in Minnesota, or 1-800/233-3889 out of state). Directories are subject to change without notice and are updated on a regular basis.

Whether you are already a Plan member or are considering enrolling in this Plan, you should review the Plan's provider directory. If you are interested in receiving care from a **specific** provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. **It is important to know that when you enroll in this plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.**

Should you decide to enroll, you will be asked to complete a primary clinic selection form and send it directly to the Plan, indicating the name of the primary clinic(s) selected for you and each member of your family. Members may change their clinic selection by notifying the Plan. Any change of your clinic will be effective the first of the following month after the Plan receives your request, if the Plan receives it by the 20th of the month. Clinic changes may not be made during the time you are receiving inpatient services.

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

Referrals for specialty care

Plan members are expected to obtain all of their medical care, including emergency care, in Plan facilities. Care may also be obtained through the 2,500 community specialists and the 90 hospitals that are referral providers for the Plan, but only after authorization and referral by a Plan doctor, Plan dentist or a Plan mental health professional. There are limited exceptions for emergency care. The Plan will not pay for unauthorized charges.

Authorizations

Your primary care doctor must obtain authorization from the Plan before you may be hospitalized, referred for specialty care or obtain follow-up care from a specialist.

Facts about this Plan *continued*

For new members

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

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

Hospital care

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

Out-of-pocket maximum

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

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

Deductible carryover

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

Submit claims promptly

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

Other considerations

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

The Plan’s Service and Enrollment Areas

The service area for this Plan, where Plan providers and facilities are located, is the enrollment area listed on the front cover of this brochure (the area in which you must live to enroll in the Plan). Benefits for care outside the service area are limited to emergency services, as described on page 14.

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

Pre-authorized care for enrollees temporarily outside the Service Area

If a member has an illness or condition for which services may be required and the member will be temporarily leaving the service area, the Plan covers urgently needed care from non-network providers if the care has been pre-authorized by the Plan’s medical director or his or her designee. Coverage may include professional services from a non-network doctor and hospital services, which are for scheduled care which is immediately required and cannot be delayed. The Plan’s medical director may limit the scope and duration of benefits provided under this provision. Services are covered at 80% of the first \$2,500 of expenses per year, then 100%. Preventive services, such as routine physicals and checkups, services for mental and chemical health and children’s emotional handicaps are not covered.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Circumstances beyond Plan control

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

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, benefits will be coordinated with Medicare according to Medicare's determination of which coverage is primary. Generally, you do not need to take any action after informing the Plan of your or your family member's eligibility for Medicare. Your Plan will provide you with further instructions if a Medicare claim needs to be filed

Group health insurance and automobile insurance

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

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

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

CHAMPUS

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

General Limitations *continued*

Medicaid	If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.
Workers' compensation	The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).
DVA facilities, DoD facilities, and Indian Health Service	Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.
Other Government agencies	The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.
Liability insurance and third party actions	If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with it subrogation procedures.

General Exclusions

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

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see *Emergency Benefits*)
- Expenses incurred while not covered by this Plan
- Services furnished or billed by a provider or facility barred from the FEHB Program
- Services not required according to accepted standards of medical, dental, or psychiatric practice
- Procedures, treatments, drugs or devices that are experimental or investigational
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** nothing. Within the Service Area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate. **You pay** nothing for a doctor's or nurse's house call.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilizations and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, heart/lung, single and double lung, kidney/pancreas, kidney and liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, severe, congenital combined immunodeficiency disease, Wiscott-Aldrich Syndrome, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Bone marrow transplants for diseases originating in the hematological system other than aplastic anemia and leukemia and bone marrow transplants for advanced Hodgkin's lymphoma and advanced non-Hodgkin's lymphoma are covered. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Chiropractic services. Chiropractic therapy does not include ongoing maintenance therapy or therapy other than for treatment of acute musculoskeletal conditions.
- Home health services of nurses and health aides, including intravenous fluids and medications when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need. You pay \$15 per visit for health aides, physical therapists, occupational therapists, respiratory therapists and speech therapists. All other services are covered at 100%.
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. Surgical and non-surgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder is covered. **You pay** nothing. Orthodontia related to, and oral surgery treatment for, cleft lip and palate is covered for dependent children. **You pay** 20% of the charges for related appliances. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of TMJ pain dysfunction syndrome.

Medical and Surgical Benefits *continued*

Limited benefits *continued*

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. **You pay** 20% of the charges.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months; **you pay** nothing. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infraction, is covered for Phase I. Phase II therapy is covered when approved by the Plan. **You pay** nothing.

Orthopedic devices, such as braces, **prosthetic devices**, such as artificial limbs, and **durable medical equipment**, such as external lenses following cataract surgery or accident, foot orthotics, wheelchairs and hospital beds, are covered. **You pay** 20% of charges up to a Plan maximum payment of \$2,000 per piece of durable medical equipment (\$5,000 aggregate maximum) and \$5,000 per prosthetic device (duplicate prosthetic devices are excluded) per calendar year. The maximum payment for an electric wheelchair is \$8,000 if approved by the Plan. Payment for an electric wheelchair does not apply to the aggregate maximum per calendar year. The costs of orthopedic devices are not limited. The maximum payment per item and aggregate maximum per calendar year do not apply to diabetic supplies or high frequency chest compression devices used in the treatment of cystic fibrosis and ventilators.

Diagnosis and treatment of infertility is covered; **you pay** 20% of charges. **Artificial insemination** is covered. Cost of donor sperm is not covered. Fertility drugs are covered. **Other assisted reproductive technology (ART) procedures** such as in vitro fertilization and embryo transfer are not covered. Infertility drugs are covered under the Prescription Drug benefit.

Surgical treatment of morbid obesity is covered. **You pay** 20% of the charges.

Breast reduction surgery and **penile and cochlear implants** are covered. **You pay** 20% of the charges.

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

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Plastic surgery primarily for cosmetic purposes, including breast augmentation procedures
- Transplants not listed as covered
- Speech therapy services to correct development delays
- Infertility treatment following reversal of voluntary sterilization
- Blood and blood derivatives (no charge if replacement is arranged by member)
- Hearing aids
- Homemaker services
- Health club memberships and surgery or hospitalization for purposes of weight reduction
- Long-term rehabilitative services

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay nothing. All necessary services are covered,** including:

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

Extended care

The Plan provides a comprehensive range of benefits for up to 150 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay nothing. All necessary services are covered,** including:

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

Hospice Care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient care; family counseling and respite and continuous care. Coverage for respite care is limited to five days. Periods of respite and continuous care combined are limited to thirty days. These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. **You pay nothing** for part-time and intermittent care provided in the home, inpatient services, medications for pain and symptom management, durable medical equipment and continuous care. **You pay 20%** of charges for periods of respite care.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. **You pay 20%** of the charges. Transfers between hospitals for treatment by Plan physicians are covered at 100% if initiated by a Plan physician.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 15 for nonmedical substance abuse benefits.

What is not covered

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

Emergency Benefits

What is a medical emergency?

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

Emergencies within the Service Area

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

If you need to be hospitalized, the Plan **must** be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency **only** if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Plan pays...

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

You pay...

\$40 per hospital emergency room visit or \$10 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital within 24 hours, the emergency care copay is waived.

Emergencies outside the Service Area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Plan pays...

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

You pay...

\$40 per hospital emergency room visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is not covered

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

Emergency Benefits *continued*

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page

Mental Conditions/Substance Abuse Benefits

Mental Conditions

What is covered

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

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

Outpatient care

All necessary outpatient care from Plan doctors, consultants, or other psychiatric personnel. **You pay nothing.**

Inpatient care

All necessary inpatient care when hospitalized under the care of Plan provider. **You pay nothing.**

What is not covered

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

Substance Abuse

What is covered

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

Outpatient care

All necessary outpatient care. **You pay nothing.**

Inpatient care

All necessary treatment in a substance abuse rehabilitation (intermediate care) care program in an alcohol detoxification or rehabilitation center approved by the Plan.

What is not covered

- Treatment that is not authorized by a Plan doctor.

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply; 240 milliliters of liquid (8oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (e.g., one inhaler, one vial ophthalmic medication or insulin). **You pay** a \$8 copay per prescription unit or refill for generic drugs or for name brand drugs when generic substitution is not permissible. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, **you pay** the price difference between the generic and name brand drug as well as the \$8 copay per prescription unit or refill.

Covered medications and accessories include:

- Drugs that by law require a prescription
- Oral and injectable contraceptive drugs and contraceptive barrier devices, such as diaphragms – up to a three cycle supply of oral contraceptives or each barrier device, may be obtained for a single copay charge
- Insulin, with a copay charge applied to each vial
- Disposable needles and syringes needed to inject covered prescribed medication, including insulin
- Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits.

Limited benefits

- Infertility drugs, growth hormones and diabetic supplies (including glucose test tablets and test tape, Benedict's solution or equivalent and acetone test tablets) are covered. **You pay** 20% of the charges.
- Injectable and implantable contraceptive devices are covered. **You pay** 25% of charges.
- Migraine injections are covered, subject to 20% coinsurance, applicable to each manufacturer's package.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Contraceptive devices (other than described above)
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Drugs to aid in smoking cessation, including nicotine patches
- Drugs to encourage weight reduction

Other Benefits

Dental care

What is covered

The following preventive and diagnostic dental services are covered when provided by participating Plan dentists for children through age 18. **You pay** nothing.

- Oral exam (per Plan dentist's recommendation)
- Prophylaxis or cleaning (per Plan dentist's recommendation)
- Annual topical application of fluoride
- Preventive dental instructions
- X-rays, including bite wings (one set annually) and panoramic (complete set every five years)

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury (not chewing or biting) while the member is covered under the FEHB Program. Services must be received within one year of the date that such injury occurs. **You pay** 20% of the charges.

What is not covered

Other dental services not shown as covered

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, one eye refraction every two years (to provide a written lens prescription) may be obtained from Plan providers. **You pay** nothing.

What is not covered

- Corrective eye lenses, frames, or contact lenses (included the fitting of the lenses)
- Eye exercises
- Radial keratotomy

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Non-FEHB Benefits Available to Plan Members

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

Medicare prepaid plan enrollment – This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare without payment of an FEHB premium. As indicated on page 4, certain annuitants and former spouses who are covered by both Medicare Parts A and B and FEHB may elect to drop their FEHB coverage and later reenroll in FEHB. Contact your retirement system for information on changing your FEHB enrollment. Contact us at 883-5600 for information on the Medicare prepaid plan and the cost of that enrollment.

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

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Service Office at 612/399-2000 or 1-800/245-0655 (hearing impaired individuals should call 1-800/443-0156 in the state, or 1-800/233-2889 out-of-state).

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

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

OPM review

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

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

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

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

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

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

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

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

How to Obtain Benefits *continued*

OPM review *continued*

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

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

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

How HealthPartners Health Plan Changes January 1997

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

Benefit changes

Under the "Facts About HealthPartners Health Plan", the out-of-pocket maximum for s Self and Family enrollment is \$5,000. Previously, the maximum was \$9,000.

Under the "Medical and Surgical Benefits" provision, pancreas/kidney transplants are covered.

Under the "Medical and Surgical Benefits" section, the maximum payment for an electric wheelchair is increased to \$8,000.

Under the "Hospital/Extended Care Benefits" provision, Hospice care is covered. See page 13 for details.

Under the "Mental Conditions Benefits" provision, all necessary outpatient and inpatient care is covered without a dollar or day limit.

Under the "Substance Abuse Benefits" provision, all necessary outpatient and inpatient care is covered without a dollar or day limit.

Under the "Prescription Drug Benefits" provision, members pay a \$8 copay per prescription unit or refill. Previously, members paid a \$9 copay per prescription unit or refill.

Clarifications

Under the "Medical and Surgical Benefits" provision, "Non-experimental implants is replaced with "The insertion of internal prosthetic devices, such as pacemakers and artificial joints."

Under the "Medical and Surgical Benefits" provision, double lung transplants are covered

- The use of a Plan identification card to obtain benefits after you are no longer enrolled in the Plan is a fraudulent action subject to review by the Inspector General.
- Medical data that does not identify individual members may be disclosed as a result of bona fide medical research or education.
- General Information When a family member is hospitalized on the effective date of an enrollment change and continues to receive benefits under the old plan, benefits under the new plan will begin for other family members on the effective date of the new enrollment.

An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition.

How HealthPartners Health Plan Changes January 1997 *continued*

Clarifications

continued

Annuitants and former spouses with FEHB coverage, and who are covered by Medicare Part B, may join a Medicare prepaid plan if they do not have Medicare Part A, but they will probably have to pay for hospital coverage. They may also remain enrolled under an FEHB plan when they enroll in a Medicare prepaid plan.

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

Temporary continuation of coverage (TCC) for employees or family member who lose eligibility for FEHB coverage includes one free 31-day extension of coverage and may include a second. How these are coordinated has been clarified; notification and election requirements have also been clarified.

- “Conversion to individual coverage” does not require evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions; benefits and rates under the individual contract may differ from those under the FEHB Program.
- “Nonexperimental implants” is now termed “The insertion of internal prosthetic devices”.

Other changes

- Enrollees who change their FEHB enrollments using Employee Express may call the Employee Express HELP number to obtain a letter confirming that change if their ID cards do not arrive by the effective date of the enrollment change.
- The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers’ compensation. The Plan is entitled to be reimbursed by OWCP for services it provided that were later found to be payable by OWCP.
- Disputed claims If your claim for payment or services is denied by the Plan, and you decide to ask OPM to review that denial, you must first ask the Plan to reconsider their decision. You must now request their reconsideration within six months of the denial (previously, you had one year to do this). This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.

Providers, legal counsel, and other interested parties may act as your representative in pursuing payment of a disputed claim only with your written consent. Any lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan must be brought against the Office of Personnel Management in Federal court and only after you have exhausted the OPM review procedure.

HealthPartners Health Plan Service and Enrollment Area Zip Codes

54001-54007	55065-55066	55932	56110-56111
54009-54017	55068-55071	55940	56114
54020-54028	55073-55080	55944-55946	56117-56123
54082	55082-55085	55955-55957	56125-56127
54610	55087-55090	55960	56129
54622	55092	55963-55964	56131
54629	55100-55128	55968	56137
54721	55133	55978	56141
54723	55144-55146	55981-55983	56143
54736	55150	55985	56145
54740	55155	55991-55992	56150-56151
54743	55161	56001-56003	56153
54750	55164-55166	56006	56155
54755-54756	55168-55172	56010-56011	56159-56162
54759	55175	56013-56014	56165
54761	55177	56016-56017	56167-56168
54764	55182	56019	56171-56172
54767	55190-55191	56021-56028	56174
54769	55301-55309	56030-56031	56176
54810	55311-55325	56033-56035	56181
54824-54825	55327-55331	56037	56183
54837	55334-55399	56039	56185
54851	55401-55450	56041-56042	56187
54853	55454-55455	56044-56048	56228
54858	55458-55460	56050-56058	56243
55001-55003	55468	56060	56246
55005-55006	55470	56062-56063	56253
55008-55014	55472-55473	56065	56273
55016-55021	55478-55480	56067-56069	56301-56304
55024-55027	55483-55488	56071-56075	56307-56308
55029	55550-55599	56077-56078	56310
55031-55033	55901	56080-56082	56312-56314
55038	55903	56084-56085	56316-56321
55040-55047	55917-55918	56087-56088	56324-56325
55049	55920	56090-56093	56328-56331
55052-55057	55924	56096-56098	56333-56336
55060	55927	56101	56338

HealthPartners Health Plan Service and Enrollment Area Zip Codes

56340	56584-56589	58102-58109
56344-56345	56591	58121-58124
56347	56593-56594	58126
56352-56353	56601	58218-58219
56355-56357	56619	58223
56359-56364	56621	58230
56367-56369	56630	58240
56371-56380	56633-56634	58257
56382	56644	58274
56384-56385	56647	58277
56387	56650	58401-58402
56389	56652	58405
56393	56663	58411
56395-56398	56666-56667	58415
56436	56670-56671	58420
56438	56674	58424
56440	56676	58426
56443	56678	58429
56449	56683	58431-58433
56460-56461	56685	58440
56466	56687	58442
56475	58001-58009	58454-58456
56501-56502	58011-58018	58458
56510-56511	58021	58461
56513-56516	58027	58466-58467
56518-56522	58029-58033	58472
56524-56525	58035-58036	58476
56527-56529	58038-58043	58479-58481
56533-56534	58045-58049	58483
56536-56538	58051-58054	58490
56541	58056-58065	58492
56543-56554	58067-58069	58496-58497
56557	58071-58072	58561
56560-56563	58074-58075	58768
56566-56567	58077-58079	
56569-56581	58081	

Summary of Benefits for HealthPartners Health Plan - 1997

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

Benefits	Plan pays/provides	Page
Inpatient Hospital care	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing	13
Extended Care	All necessary services, for up to 150 days per year. You pay nothing	13
Mental Conditions	All necessary inpatient care without dollar or day limit. You pay nothing	15
Substance Abuse	All necessary inpatient care without a dollar or day limit. You pay nothing.....	15
Outpatient care	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay nothing for office visit or for house calls by a doctor or nurse	11
Home Health Care	All necessary visits by nurses and health aides. You pay a \$15 copay per visit for physical therapy, occupational therapy, speech therapy, respiratory therapy and home health aide services	11
Mental Conditions	All necessary outpatient care without a dollar or day limit.....	15
Substance Abuse	All necessary outpatient care without a dollar or day limit. You pay nothing.....	15
Emergency care	Reasonable charges for services and supplies required because of a medical emergency. You pay a \$40 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan. Urgent Care Benefit, see page 14.	14
Prescription drugs	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay a \$8 copay per prescription unit or refill	16
Dental care	Accidental injury benefit; you pay 20% of the charges. Preventive dental care through age 18; you pay nothing.....	17
Vision care	One refraction every two years. You pay nothing	17
Out-of-pocket limit	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of \$3,000 per member per calendar year, or \$9,000 for a family, covered benefits will be provided at 100%	8