HealthPartners
High Option and Standard Option

www.healthpartners.com/fehb
Customer Service 1-800-883-2177

HealthPartners® **2014**

A Health Maintenance Organization (high and standard option) This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides.

IMPORTANT
- Rates: Back Cover
- Changes for 2014: Page 15
- Summary of benefits: Page 88

Serving: The entire state of Minnesota and surrounding communities in Western Wisconsin, Northern Iowa, and Eastern North and South Dakota.

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

HealthPartners has been awarded "Excellent" Accreditation for most of its commercial HMO and Medicare Advantage 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:

V31 High Option - Self Only:
V32 High Option - Self and Family
V34 Standard Option - Self Only
V35 Standard Option - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from HealthPartners About
Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the HealthPartners High Option and Standard Option prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all Plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB Plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

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Introduction

This brochure describes the benefits of the HealthPartners High Option and the Standard Option Plan under our contract (CS 2875) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The minimum value standard is 60% (actuarial value.) Customer service may be reached at 952-883-5000 or 1-800-883-2177 (TTY 952-883-5127) or through our website: www.healthpartners.com/fehb. This Plan is underwritten by Group Health, Inc. The address for HealthPartners administrative office is: Group Health, Inc., dba HealthPartners, Inc., 8170 33rd Avenue South, Bloomington, MN 55425.

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, 2014, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2014, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Indicidual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 6% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means HealthPartners.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States 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.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits 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 that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits 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) statements that you receive from us.

- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.

- 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 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
877-499-7295
OR go to www.opm.gov/oig

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- 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)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use HealthPartners Open Access Network preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

Minimum essential coverage (MEC)

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Indicidual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

Minimum value standard

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 6% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/healthcare-insurance for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* 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
- What happens when your enrollment ends
- 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. For information on your premium deductions, you must also contact 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 dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 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 benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment or when your child reaches age 26.

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.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events . If you need assistance, please contact your employing agency, Trival Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance

- **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 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 Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- 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 cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective 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. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2014 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2013 benefits until the effective date of your coverage with your new plan. 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.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

  If you are divorced from a Federal employee, Tribal employee, or an 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 provide health coverage for you. However, you may be eligible for your own FEHB coverage under either 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 Benefits 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/healthcare-insurance/healthcare/plan-information/guides

- **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 Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

  You may not elect TCC if you are fired from your Federal or Tribal 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

  We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

- **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 or Tribal 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.

- **Health Insurance Market Place**

  If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Servies that provides up-to-date information on the Marketplace

- **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 at www.opm.gov/insure/healthcare-insurance; 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 information about Federal and State agencies you can contact for more information.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We generally 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 our most recent provider directory. There is one provider directory for both Plan options. We give you a choice of enrollment in a High Option or a Standard Option.

Except as allowed under our Temporary Residence program, we will pay only for emergency care benefits if you receive care outside of our service area.

The plans 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 the Plan's Open Access Network providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance and deductibles described in this brochure. When you receive emergency services from non-plan providers and when you use the out-of-network benefit of Standard Option, you may have to submit claim forms.

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

Our network is subject to change. For the most current information on the network, visit our website at www.healthpartners.com/fehb or call us at 952-883-5000 or 1-800-883-2177 (TTY 952-883-5127).

General features of our High and Standard Options

The Planslet you receive care from a large network of providers in the HealthPartners Open Access Network across Minnesota, western Wisconsin, northern Iowa and eastern North and South Dakota. Referrals are not required and you do not need to choose a primary care clinic. Any time you or a member in your family needs care, you may choose to see any provider in this Network. With limited exceptions, if you seek care from a provider who does not participate in the Network, your care is considered out of network and may not be covered. Standard Option lets you obtain care in the Open Access Network or out of network within our service area.

We have Open Access benefits

The plans offer Open Access benefits. This means you can receive covered services from a HealthPartners Open Access Network participating provider without a required referral from your primary care physician or another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups and hospitals to provide the Open Access Network benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Out-of-network providers have not agreed to negotiated fees and you may be responsible for amounts above usual and customary levels.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, our providers and facilities. OPM's FEHB Web site (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 is Minnesota's only consumer-governed health Plan. Our Board of Directors is composed of consumer-elected members. HealthPartners is a licensed HMO in the State of Minnesota. Group Health, Inc., is a federally qualified HMO, and received that qualification in 1974.
- Information on the following topics is available by calling HealthPartners Member Services:
  - Details on your health plan benefits, claims and account balances

- Assistance finding and choosing a provider in your network
- Prescription drug information specific to your benefits
- A warm transfer to HealthPartners Nurse Navigator program staffed by experience nurses who help research treatment options, coordinate care and guide you through difficult decisions

• Member Services representatives are available from 7 a.m. until 6 p.m., Monday through Friday, Central Standard Time.

If you want more information about us, call 952-883-5000 or 1-800-883-2177 (TTY 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/fehb.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service area

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

The following counties in Minnesota (includes all counties in Minnesota): Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cook, Cottonwood, Crow Wing, Dakota, Dodge, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hennepin, Houston, Hubbard, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac Qui Parle, Lake, LeSueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Pipestone, Polk, Pope, Ramsey, Red Lake, Redwood, Renville, Rice, Rock, Roseau, St. Louis, Scott, Sherburne, Sibley, Stearns, Steele, Stevens, Swift, Todd, Traverse, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright and Yellow Medicine.

The following counties in Iowa: Allamakee, Black Hawk, Bremer, Buchanan, Buena Vista, Cerro Gordo, Cherokee, Chickasaw, Clay, Clayton, Delaware, Dickinson, Emmet, Fayette, Floyd, Hancock, Howard, Kossuth, Lyon, Mitchell, O'Brien, Osceola, Palo Alto, Plymouth, Pocahontas, Sioux, Winnebago, Winneshiek, Woodbury and Worth.

The following counties in North Dakota: Adams, Barnes, Benson, Bottineau, Bowman, Burleigh, Cass, Cavalier, Dickey, Eddy, Emmons, Foster, Grand Forks, Grant, Griggs, Hettinger, Kidder, LaMoure, Logan, McHenry, McIntosh, McLean, Mercer, Morton, Mountaintrail, Nelson, Pembina, Pierce, Ramsey, Ransom, Renville, Richland, Rolette, Sargent, Sheridan, Sioux, Stark, Steele, Stutsman, Towner, Traill, Walsh, Ward and Wells.

The following counties in South Dakota: Aurora, Beadle, Bon Homme, Brookings, Brown, Brule, Campbell, Charles Mix, Clark, Clay, Codington, Corson, Davison, Day, Deuel, Douglas, Edmunds, Faulk, Grant, Gregory, Hamlin, Hand, Hanson, Harding, Hughes, Hutchinson, Hyde, Jerauld, Jones, Kingsbury, Lake, Lincoln, Lyman, Marshall, McCook, McPherson, Miner, Minnehaha, Moody, Perkins, Potter, Roberts, Sanborn, Spink, Tripp, Turner, Union, Walworth and Yankton.

The following counties in Wisconsin: Adams, Ashland, Barron, Bayfield, Buffalo, Burnett, Chippewa, Clark, Crawford, Douglas, Dunn, Eau Claire, Grant, Iron, Jackson, Juneau, La Crosse, Marathon, Monroe, Oneida, Pepin, Pierce, Polk, Portage, Price, Richland, Rusk, St. Croix, Sauk, Sawyer, Taylor, Trempeleau, Vernon, Vilas, Washburn and Wood.

To receive in-network benefits, you must get your care from providers who contract with us. You will receive your out-of-network benefits if you receive care within our service area from a provider that is not contracted with us. Except as allowed under our Temporary Residence program, we will pay only for emergency care benefits if you receive care outside of our service area.

If you or a covered family member move outside of our service area, you can enroll in another plan. 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. Changes for 2014

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

Changes to High Option only

- Copays for virtuwell TM are $0 for the first three visits per person in a calendar year, then $10 per visit. See page 28.
- Your share of the non-Postal premium will decrease for Self Only and for Self and Family. See page 90.

Changes to Standard Option only

- Your share of the non-Postal premium will remain the same for Self Only and for Self and Family. See page 90.

Changes to both High Option and Standard Option plans

- $75 incentive, in the form of a gift card to be used towards wellness products, for each adult employee or spouse who registers for online services and completes an online health assessment and an eligible online health improvement program (Limit one inventive per adult employee or spouse per calendar year). Total maximum incentive amount is $75 Self and $150 Family. Additional information is available at www.healthpartners.com/fehb

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 letter (for annuitants) or your electronic enrollment system (such as 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 (TTY 952-883-5127) or write to us at Member Services, P.O. Box 1309, Minneapolis, MN 55440-1309. You may also request replacement cards through our website at www.healthpartners.com/fehb.

Where you get covered care

In Network: You get care from "Plan providers" and "Plan facilities." You will pay copayments, deductibles, and/or coinsurance. You can receive covered services from a participating provider without a referral from your primary care physician or another participating provider in the network.

Out of Network (Standard Option): You may choose to use your out-of-network benefit and receive care from any licensed provider in our service area. You may be billed for these services and may need to file a claim for reimbursement.

Members with a temporary residence outside our service area may receive plan benefits upon prior notification to HealthPartners. Absences from the service area for school, seasonal living, or other purposes must be at least 30 days but no more than 280 days in length. Members can apply this benefit to only one temporary residence during this time period. For additional program information and a listing of available national network providers, visit our website at www.healthpartners.com/fehb or call us at 952-883-5000 or 1-800-883-2177 (TTY 952-883-5127). This does not apply to preventive and diagnostic dental services.

- **Plan providers**

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

We list Plan providers in the HealthPartners Open Access Network provider directory, which we update periodically. For information that is updated weekly, visit www.healthpartners.com/fehb.

This Plan lets you receive care from more than 34,000 providers in the Open Access Network across Minnesota, western Wisconsin, northern Iowa and eastern North and South Dakota. Referrals are not required and you do not need to choose a primary care clinic. Any time you or a member in your family needs care, you may choose to see any provider in this network.

High Option: With limited exceptions, if you seek care from a provider who does not participate in the Open Access Network, but is within our service area your care is considered out of network and may not be covered.

Standard Option: With limited exceptions, if you seek care from a provider who does not participate in the Open Access Network, your care is considered out of network and the lower out-of-network benefits apply.

- **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 Open Access Network provider directory, which we update periodically. The list is on our website: www.healthpartners.com/fehb.

High Option: With limited exceptions, if you seek care from a facility that does not participate in the Open Access Network, your care is considered out of network and may not be covered.

Standard Option: With limited exceptions, if you seek care from a facility that does not participate in the Open Access Network, but is within our service area, your care is considered out of network and the lower out-of network benefits apply.

What you must do to get covered care

High Option: Any time you or a member in your family needs care, you should choose to see any provider in the Open Access Network. With limited exceptions, if you seek care from a provider who does not participate in the Network your care is considered out of network and may not be covered.

Standard Option: You may choose to use your out-of-network benefit and receive care from any licensed provider in our service area. You may be billed for these services and may need to file a claim for reimbursement.

- **Temporary Residence**

Members with a temporary residence outside our service area may receive plan benefits upon prior notification to HealthPartners. Absences from the service area for school, seasonal living, or other purposes must be at least 30 days but no more than 280 days in length. Members can apply this benefit to only one temporary residence during this time period. For additional program information and a listing of available national network providers, visit our website at www.healthpartners.com/fehb or call us at 952-883-5000 or 1-800-883-2177 (TTY 952-883-5127). This does not apply to preventive and diagnostic dental services.

- **Primary care**

Members are not required to pick a primary clinic. However, we encourage members to work with personal physicians who will get to know them. Primary care providers are providers in the following categories: family and general practice, internal medicine, pediatrics, adolescent medicine, adult medicine and geriatrics. Your primary care physician will provide most of your health care or suggest that you see a specialist. You can see any specialist without a referral.

If you want to change your primary care physician or if your primary care physician leaves the Plan, simply choose another provider from the Open Access Network directory for in-network benefits. For the most up-to-date network provider information, visit www.healthpartners.com/fehb, where information is updated weekly.

- **Specialty care**

Specialty care providers are providers who are not in the following categories: family and general practice, internal medicine, pediatrics, adolescent medicine, adult medicine and geriatrics.

You have direct access to any specialist in the Open Access Network without a referral.

If you are seeing a specialist when you enroll in our Plan and 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 Member Services at 952-883-5000 or 1-800-883-2177 for assistance. 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;
- 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.

- **Designated providers** — You may be required to see a designated provider for transplants and bariatric surgery. A designated provider is a health care provider, group or association of health care providers designated by us to provide services, supplies or drugs for specified transplants or bariatric surgery.
- **Hospital care** — Your 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 hospitalized when your enrollment begins** — We pay for covered services from the effective date of your enrollment. However, 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 (TTY 952-883-5127). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

  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;
  - 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. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.
- **Determination of coverage** — We cover eligible services only when medically necessary for the proper treatment of a member. Our medical or dental directors, or their designees, make coverage determinations of medical necessity, restrictions on access and appropriateness of treatment, and they make final authorization for covered services. Coverage determinations are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission** — **Precertification/Prior-authorization** is the process by which -- prior to your inpatient hospital admission -- we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.
- **Other services** — Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior 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 physician must obtain prior authorization for services such as:

  - Reconstructive surgery
  - Promising therapies/new technologies

- Transplants
- Medically necessary dental care, such as orthognathic surgery
- Durable medical equipment and prosthetics
- Home health care
- Skilled nursing care
- Hospice care
- Habilitative therapy
- Bariatric surgery
- Growth hormone therapy (GHT)

The complete list, along with the criteria we use to review authorization requests, is available on www.healthpartners.com/fehb or by calling HealthPartners Member Services at 952-883-5000 or 1-800-883-2177 (TTY 952-883-5127). Your physician is responsible for obtaining prior authorization.

How to request precertification for an admission or get prior authorization for other services

First your physician, your hospital, you, or your representative, must call us at 952-883-6333 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- Enrollee's name and Plan identification number
- Patient's name, birth date, identification number and phone number
- Reason for hospitalization, proposed treatment, or surgery
- Name and phone number of admitting physician
- Name of hospital or facility
- Number of planned days of confinement

- **On the Standard Option, precertification for certain non-emergency services provided by out-of-network providers within the service area**

CareCheck® must precertify all inpatient confinement and same day surgery, new, experimental or reconstructive outpatient technologies or procedures, durable medical equipment or prosthetics costing over $3,000, home health services after your visits exceed 30, and skilled nursing facility stays. When you call CareCheck®, a utilization management specialist reviews your proposed treatment plan. CareCheck® provides certification and determines appropriate length of stay, additional days and reviews the quality and appropriateness of care.

How to contact CareCheck®: You may call **952-883-6400** in the Minneapolis/St. Paul metro area or **1-800-316-9807** outside the metro area from 8 a.m. to 5 p.m. (Central Time) weekdays. You can leave a recorded message at other times. You may also write CareCheck® at Quality Utilization Management Department, 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 952-883-5000 or 1-800-883-2177 (TTY 952-883-5127. You may also call OPM's Health Insurance 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 952-883-5000 or 1-800-883-2177 (TTY 952-883-5127. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 72 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

- **Failure to comply with CareCheck®** requirements

On the Standard Option, with respect to Out-of-Network benefits provided in the service area, if you fail to make a request for precertification of services in the time noted above, but your services requiring precertification are subsequently approved as medically necessary, we will reduce the eligible charges by 20%.

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.

If you disagree with our pre-service claim decisions

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

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.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your pre-service claim, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your cost for covered services

This is what you will pay out of pocket for covered care.

Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: With High Option, when you see your primary care physician you pay a copayment of $25 per office visit.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.
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. **High Option:** There is no calendar year deductible for medical care. There is a $50 calendar year deductible for emergency dental services. **Standard Option:** **For Network Expenses:** The calendar year deductible is $1,000 for persons enrolled for Self Only coverage and $2,000 for families enrolled for Self and Family coverage. **For Out-of-Network Expenses:** The calendar year deductible is $2,000 for persons enrolled for Self Only coverage and $4,000 for families enrolled for Self and Family coverage. 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. 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 (our plan allowance) that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: In our Plan, you pay 20% of our allowance for durable medical equipment.
Your catastrophic protection out-of-pocket maximum	**High Option:** If you are enrolled for Self Only coverage, when your copayments, coinsurance and/or dental deductible total $4,000 in a calendar year, you do not have to pay any more for covered services for the remainder of that calendar year. If you are enrolled for Self and Family coverage, when your family's copayments, coinsurance and/or dental deductible total $8,000 in a calendar year, you and your dependents do not have to pay any more for covered services for the remainder of that calendar year. **Standard Option: In Network:** If you are enrolled for Self Only coverage, when your deductible, copayments and/or coinsurance total $5,000 in a calendar year, you do not have to pay any more for covered services for the remainder of that calendar year. If you are enrolled for Self and Family coverage, when your family's deductible, copayments and/or coinsurance total $10,000 in a calendar year, you and your dependents do not have to pay any more for covered services for the remainder of that calendar year. **Out of Network:** There is no limit on your out-of-pocket expenses.

Carryover	If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.
When Government facilities bill us	Facilities of the Department of Government Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. High and Standard Option benefits

See page 15 for how our benefits changed this year. Pages 87 and 88 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option benefits overview

This Plan offers both a High and a Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. 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 High and Standard Option benefits, contact us at 952-883-5000 or 1-800-883-2177 (TTY 952-883-5217) on our website at www.healthpartners.com/fehb.

Each option offers unique features.

High Option:

- HealthPartners' service area includes all Minnesota counties, plus western Wisconsin, northern Iowa and eastern North and South Dakota
- You don't need to choose a primary clinic
- You can see any network provider – primary care or specialist – without a referral
- Preventive services, including routine eye exams and hearing exams, are covered at 100%
- Preventive dental is covered at 100%
- $75 incentive, in the form of a gift card, for each adult employee or spouse who completes an online health assessment and an eligible online health improvement program.

Standard Option:

- HealthPartners' service area includes all Minnesota counties, plus western Wisconsin, northern Iowa and eastern North and South Dakota
- You don't need to choose a primary clinic
- You can see any provider – primary care or specialist – without a referral
- In Network: Preventive services, including routine eye and hearing exams, are covered at 100%
- In Network: Each year, each member's first three office visits are covered at 100%
- Deductibles apply to most services except as listed
- Generic drug copay has no deductible
- $75 incentive, in the form of a gift card, for each adult employee or spouse who completes an online health assessment and an eligible online health improvement program.

Both Options - As a member of either option, you have access to:

- Worldwide emergency care
- HealthPartners' nationally recognized disease and case management programs
- Temporary Residence Benefits

Important things you should 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
- To receive in-network benefits, you must use a physician in our provider network
- Be sure to read Section 4, Your Cost for Covered Services, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

Important things you should 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.
- For you to receive in-network benefits, Plan physicians must provide your care.
- For Standard Option. For Network Expenses: The calendar year deductible is $1,000 for persons enrolled for Self Only coverage and $2,000 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage and $4,000 for families enrolled for Self and Family coverage. The calendar year deductible applies to almost all Standard Option benefits in this Section. We added "deductible does not apply" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Cost for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
For Standard Option Three for Free, a calendar year deductible applies to almost all benefits in this Section. We specify when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
We cover professional services of physicians: • In an office • 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 • Injections administered in an office (other than specialty drugs described below) Note: List of qualifying clinics is available at www.healthpartners.com/fehb.	$25 per office visit for primary care; $45 per office visit for specialty care	In Network: $0 for the first 3 office, convenience clinic, telephone, and urgent care visits and evisits combined in calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services are included; however, charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance. Out of Network: 40% of charges after out-of-network deductible
• At a convenience clinic Note: For a list of convenience clinics, see your provider directory, call Member Services or visit our website at www.healthpartners.com/fehb.	$10 per office visit	

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
		In Network: $0 for the first 3 office, convenience clinic, telephone and urgent care visits and evisits combined in calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services are included; however, charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance. Out of Network: 40% of charges after out-of-network deductible
Specialty drugs administered in an office We cover specialty drugs that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/AIDS.	20% of charges	In Network: 25% of charges, after deductible Out of Network: All charges
• Through virtuwell™, our online benefits program at www.virtuwell.com Note: Available only to plan members residing in MN or WI.	$0 for the first three virtuwell™ visits per person in a calendar year, then $10 per visit, for the remainder of the year.	$0 for the first three virtuwell™ visits per person in a calendar year (not subject to the deductible), then 20% of charges, subject to the in-network deductible, for the remainder of the calendar year.
• In an urgent care center	$45 per office visit	In or Out of Network: $0 for the first 3 office, convenience clinic, telephone, and urgent care visits and evisits visits combined in calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services are included; however, charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance.

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
• During a hospital stay • In a skilled nursing facility	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of inpatient hospital charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• At home physical therapy, occupational therapy, speech therapy, respiratory therapy and home health aide services	$45 per visit	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• Specialty drugs administered in home We cover specialty drugs that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/AIDS.	20% of charges	In Network: 25% of charges, after deductible Out of Network: All charges
Not covered: Genetic counseling and studies not required for diagnosis and treatment	*All charges*	*All charges*
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
We cover tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• MRI/CT scans	20% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Preventive care, adult	**High Option**	**Standard Option**
We cover 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	Nothing	In Network: Nothing Out of Network: 40% of charges after out-of-network deductible

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
- Colonoscopy screening – every 10 years starting at age 50 • Routine prostate specific antigen (PSA) test – one annually for men age 40 and older • Well woman care, including but not limited to: - Routine pap test - Human papillomavirus testing for women age 30 and up once every three years. - Annual counseling for sexually transmitted infections - Annual counseling and screening for human immunodeficiency virus - Contraceptive methods and counseling - Screening and counseling for interpersonal and domestic violence • 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 routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) 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	In Network: Nothing Out of Network: 40% of charges after out-of-network deductible
We cover online account, online health assessment and online wellness courses	$75 incentive, in the form of a gift card to be used towards wellness products, for each adult employee or spouse who registers for online services and completes an online health assessment and an eligible online health improvement program (Limit one inventive per adult employee or spouse per calendar year). Total maximum incentive amount is $75 Self and $150 Family.	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
	Additional information is available at www.healthpartners.com/fehb	
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
We cover: • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics • Routine hearing and eye exams	Nothing	In Network: Nothing Out of Network: 40% of charges after out-of-network deductible
Maternity care	**High Option**	**Standard Option**
We cover complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Postnatal care	Nothing for routine prenatal care, the first postpartum care visit or routine gestational diabetes screening. $25 per office visit for primary care; $45 per office visit for specialty care for postpartum care visits thereafter.	In Network: Nothing for routine prenatal care, the first postpartum care visit or routine gestational diabetes screening. For all postpartum visits thereafter: $0 for the first 3 office, convenience clinic, telephone, and urgent care visits and evisits combined in calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services are included; however, charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance. Out of Network: 40% of charges after out-of-network deductible
• Delivery Note: Here are some things to keep in mind: • You do not need to prior authorize your normal delivery.	See Hospital benefits–Section 5 (c) and Surgery benefits–Section 5(b)	See Hospital benefits–Section 5 (c) and Surgery benefits–Section 5(b)

Maternity care - continued on next page

Benefit Description	You Pay	
Maternity care (cont.)	**High Option**	**Standard Option**
• 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 and other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • We pay non-routine prenatal and postnatal care the same as for illness and injury.	See Hospital benefits–Section 5 (c) and Surgery benefits–Section 5(b)	See Hospital benefits–Section 5 (c) and Surgery benefits–Section 5(b)
• Breastfeeding support, supplies and counseling for each birth	Nothing	In Network: Nothing Out of Network: 40% of charges after out-of-network deductible
Family planning	**High Option**	**Standard Option**
We cover a range of voluntary family planning services, such as: • Family planing services provided by a Plan provider or non-Plan provider	Nothing	In Network: Nothing Out of Network: 40% of charges after out-of-network deductible
• Voluntary sterilization (See *Surgical procedures* Section 5 (b))	Nothing	In Network: Nothing Out of Network: 40% of charges after out-of-network deductible
• Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	Nothing	In Network: Nothing Out of Network: 40% of charges after out-of-network deductible
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*

Benefit Description	You Pay	
Infertility services	**High Option**	**Standard Option**
We cover diagnosis of infertility	20% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
We cover treatment of infertility: • Artificial insemination - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Treatment of infertility is limited to a $5,000 maximum benefit per calendar year. Drugs for treatment of infertility are not subject to this maximum. (See "Prescription drug benefits - limited benefits" under Section 5(f) Prescription drug benefits)	20% of charges and all charges beyond $5,000 calendar year limit	In Network: 20% of charges after in-network deductible and all charges beyond the $5,000 calendar year limit (combined for In Network and Out of Network) Out of Network: 40% of charges after out-of-network deductible and all charges beyond the $5,000 calendar year limit (combined for In Network and Out of Network)
We cover drugs for treatment of infertility (limited to products listed on the Infertility Products List)	20% of charges and all charges beyond $3,000 calendar year limit	In Network: 20% of charges after in-network deductible, and all charges beyond $3,000 calendar year limit (combined for In Network and Out of Network) Out of Network: 40% of charges after out-of-network deductible, and all charges beyond $3,000 calendar year limit (combined for In Network and Out of Network)
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm or egg* • *Cost of storage of donor sperm, ova or embryo* • *Treatment of infertility after reversal of sterilization* • *Artificial insemination for surrogate pregnancy*	*All charges*	*All charges*

Benefit Description	You Pay	
Allergy care	**High Option**	**Standard Option**
We cover: • Testing and treatment • Allergy injections and serum	$25 per office visit for primary care; $45 per office visit for specialty care	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
We cover: • Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on pages 46-49. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion therapy (other than specialty drugs described below)	$45 per office visit for specialty care $500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• Blood and blood plasma (unless replaced) and blood derivatives for the treatment of blood disorders	20% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• Specialty drugs We cover specialty drugs that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/AIDS.	20% of charges	In Network: 25% of charges, after deductible Out of Network: All charges
Not covered: Growth hormones which are not for growth hormone deficiency or chronic renal insufficiency	*All charges*	*All charges*
• 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	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

Treatment therapies - continued on next page

Benefit Description	You Pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services* under *You need prior Plan approval for certain services* on page 17.	20% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Physical and occupational therapies	**High Option**	**Standard Option**
We cover, usually two months per condition per year, 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. Our Plan Medical Director will determine whether measurable progress has been made based on objective documentation.	$45 per office or outpatient hospital visit for specialty care $500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• 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.	$45 per office or outpatient hospital visit for specialty care Nothing for inpatient or outpatient hospital	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*

Benefit Description	You Pay	
Speech therapy	**High Option**	**Standard Option**
We cover: • Speech therapy for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech development. • Usually 60 visits or two months per condition per year	$45 per office or outpatient hospital visit for specialty care $500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Not covered: Long term rehabilitative therapy	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
We cover: • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (See Preventive care, adult; Preventive care, children)	Nothing	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• Hearing aids for members age 18 or younger who have hearing loss that is not correctable by other covered procedures. Coverage is limited to one hearing aid for each ear every three years.	20% of the charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible.
• Hearing aids for members over age 18 who have hearing loss that is not correctable by other covered procedures. Coverage is limited to a $500 per calendar year maximum and one hearing aid for each ear every three years.	20% of the charges	*All charges*
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them, unless noted above*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
We cover: • Eye exams to determine the need for vision correction • Annual eye refractions Note: See *Preventive care, adult*; *Preventive care, children*	Nothing	Nothing
• Diagnosis and treatment of illness and injury to the eye	$25 per office visit for primary care; $45 per office visit for specialty care	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay	
Vision services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• 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	$25 per office visit for primary care; $45 per office visit for specialty care *All charges for lens replacement beyond the initial pair*	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible *All charges for lens replacement beyond the initial pair*
Not covered: • *Eye glasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
We cover routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	$25 per office visit for primary care; $45 per office visit for specialty care	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
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*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
We cover: • Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	20% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• Orthopedic and corrective shoes when approved by this Plan based on our criteria	20% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility and ambulance services.		
• Wigs required due to hair loss caused by alopecia areata	20% of charges, and all charges beyond $350 calendar year limit	In Network: 20% of charges after in-network deductible, and all charges beyond $350 calendar year limit Out of Network: 40% of charges after out-of-network deductible, and all charges beyond $350 calendar year limit
Not covered: • *Over-the-counter foot orthotics* • *Non-custom orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *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*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment, when prescribed by your Plan physician. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs	20% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• Crutches • Walkers • Blood glucose monitors • Insulin pumps • Diabetic supplies • Disposable needles and syringes needed for the administration of covered medications Note: We reserve the right to determine if an item will be approved for rental vs. purchase.	20% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Special dietary treatment for phenylketonuria (PKU)	20% of charges	In Network: 20% of charges Out of Network: 40% of charges after out-of-network deductible
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*	*All charges*

Benefit Description	You Pay	
Home health services	**High Option**	**Standard Option**
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. You need to be homebound (i.e., unable to leave home without considerable effort due to a medical condition) to receive home health services. You do not need to be homebound to receive total parenteral nutrition/intravenous ("TPN/IV") therapy.		
• At home physical therapy, occupational therapy, speech therapy, respiratory therapy and home health aide services	$45 per visit	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• TPN/intravenous therapy (other than specialty drugs described below), skilled nursing services, nonroutine prenatal and postnatal services, and phototherapy	20% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• Specialty drugs administered in home We cover specialty drugs that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/AIDS.	20% of charges	In Network: 25% of charges, after deductible Out of Network: All charges
• Routine prenatal and postnatal services and child health services	Nothing	In Network: Nothing Out of Network: 40% of charges after out-of-network deductible
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*	*All charges*

Benefit Description	You Pay	
Chiropractic	**High Option**	**Standard Option**
We cover 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	$45 per office visit for specialty care	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Not covered: • *Naturopathic services* • *Hypnotherapy*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
We cover: • Acupuncture – by a certified Plan acupuncturist for: - anesthesia - pain relief - chemical dependency - headaches - nausea • Biofeedback for: - incontinence - headaches - musculo-skeletal spasms which do not respond to other treatments - mental/nervous disorders - neurological retraining	$25 per office visit for primary care; $45 per office visit for specialty care	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Not covered: • *Naturopathic services* • *Hypnotherapy*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
We cover: • Education for preventive services • Tobacco cessation programs, including individual/group/telephone counseling, and physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Includes up to two quit attempts and up to four counseling sessions	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You Pay	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• Physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence whether or not one is enrolled in a smoking cessation program	Nothing	Nothing
• Education for the management of chronic health problems (such as diabetes)	$25 per office visit/session	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

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

Important things you should 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.
- For you to receive in-network benefits, Plan physicians must provide your care.
- Be sure to read Section 4, *Your Cost 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 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 follows the benefits described in Section 5(a) and 5(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.
- For Standard Option. For Network Expenses: The calendar year deductible is $1,000 for persons enrolled for Self Only coverage and $2,000 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage and $4,000 for families enrolled for Self and Family coverage. The calendar year deductible applies to all Standard Option benefits in this Section.
- For Standard Option. For Out-of-Network Benefits: Transplant surgery is limited to a maximum limit of $25,000 per transplant. Payment for each Out-of-Network transplant surgery will stop when that limit is reached.

Benefit Description	You Pay	
For Standard Option, a calendar year deductible applies to all benefits in this Section.		
Surgical procedures	**High Option**	**Standard Option**
We cover 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)* • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns • Insertion of internal prosthetic devices. See 5(a) -- *Orthopedic and prosthetic devices* for device coverage information	$25 per office visit for primary care; $45 per office visit for specialty care $500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

Surgical procedures - continued on next page

Benefit Description	You Pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
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.	$25 per office visit for primary care; $45 per office visit for specialty care $500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• Surgical treatment of morbid obesity (bariatric surgery) See *Services requiring our prior approval* on page 17. See bariatric surgery criteria on www.healthpartners.com/fehb.	$25 per office visit for primary care; $45 per office visit for specialty care $500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: *All charges*
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
We cover: • 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 of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see Prosthetic devices)	$25 per office visit for primary care; $45 per office visit for specialty care $500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

Reconstructive surgery - continued on next page

Benefit Description	You Pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
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.		
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*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
We cover oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures, including non-dental treatment of temporomandibular joint dysfunction (TMJ)	$25 per office visit for primary care; $45 per office visit for specialty care $500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
We cover 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	In Network: 25% of charges after in-network deductible Out of Network: 50% of charges after out-of-network deductible
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*	*All charges*

Benefit Description	You Pay	
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental investigational review by the Plan. See *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants: - small intestine - small intestine with the liver - small intestine with multiple organs, such as the liver, stomach and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
These **blood or marrow stem cell transplants** are subject to medical necessity and experimental investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases will respond to treatment without transplant and which diseases may respond to transplant. **Allogeneic** transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced myeloproliferative disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Hemoglobinopathy • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow failure and related disorders (i.e., Fanconi's PNH, pure red cell aplasia) • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Hurler's syndrome, Marteaux-Lamy syndrome • Myelodysplasia/myelodysplastic syndromes • Paroxysmal nocturnal hemoglobinuria • Phagocytic/hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome **Autologous** transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • AL Amyloidosis • Multiple myeloma • Neuroblastoma • Recurrent germ cell tumors (including testicular, mediastinal, retroperitoneal) Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: **Allogeneic** transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Acute myeloid leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Advanced myeloproliferative disorders • Advanced myeloproliferative disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) (See National Transplant Program, Page 49) • Chronic myelogenous leukemia • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal nocturnal hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia **Autologous** transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed • Amyloidosis • Neuroblastoma	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
These Blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Allogeneic transplants for • Chronic inflammatory demyelination polyneuropathy (CIDP) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Sickle cell anemia **Autologous** transplants for • Advanced childhood kidney cancers • Advanced Ewing sarcoma • Breast cancer • Childhood rhabdomyosarcoma • Epithelial ovarian cancer • Mantle cell (Non-Hodgkin lymphoma)	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of network: 40% of charges after out-of-network deductible
National Transplant Program *Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests and donor search expense for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.*	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All Charges*	*All Charges*
Anesthesia	**High Option**	**Standard Option**
We cover professional services provided in – • Hospital (inpatient) • Skilled nursing facility	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
We cover professional services provided in – • Hospital outpatient department • Ambulatory surgical center	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
We cover professional services provided in an office	$25 per office visit for primary care; $45 per office visit for specialty care	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

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

Important things you should 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.
- For you to receive in-network benefits, Plan physicians must provide your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your Cost for Covered Services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR SOME HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior authorization.
- For Standard Option. For Network Expenses: The calendar year deductible is $1,000 for persons enrolled for Self Only coverage and $2,000 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage and $4,000 for families enrolled for Self and Family coverage. The calendar year deductible applies to all Standard Option benefits in this Section.

Benefit Description	You Pay	
For Standard Option, a calendar year deductible applies to all benefits in this Section.		
Inpatient hospital	**High Option**	**Standard Option**
We cover room and board, such as • Ward, semiprivate or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
We cover 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 or 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	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• Medical supplies, appliances, medical equipment and any covered items billed by a hospital for use at home • MRI / CT scans	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
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*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
We cover: • 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 • 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.	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• MRI / CT scans • Blood and blood plasma (unless replaced) and blood derivatives	20% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• Specialty drugs We cover specialty drugs that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/AIDS.	20% of charges	In Network: 25% of charges, after in-network deductible Out of Network: All charges

Benefit Description	You Pay	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
We cover a comprehensive range of benefits for up to 120 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.	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Not covered: Custodial care	*All charges*	*All charges*
Home hospice care	**High Option**	**Standard Option**
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, when medically necessary • Respite care Note: Respite care is limited to 5 days per episode, and respite care and continuous care combined are limited to 30 days.	Nothing	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

Home hospice care - continued on next page

Benefit Description	You Pay	
Home hospice care (cont.)	**High Option**	**Standard Option**
Note: *Inpatient hospital care:* designed for those patients who require an acute hospital admission for pain or symptom control related to the terminal illness. *Free-standing hospice*: a hospice inpatient unit set up as a geographically distinct building. *Residential hospices/hospice houses:* goal is to provide longer-term care, in homelike settings, for patients who cannot be cared for in their own homes. Staffing and intensity of services are comparable to a board-and-care home or other types of licensed residential facility. A residential hospice program may be operated by a home care hospice or by an independent agency that contracts with a community hospice for professional services. Payment for residential room and board is made privately.	Nothing	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Not covered: • *Independent nursing, homemaker services* • *Room and board expenses in a residential hospice facility, free standing hospice or skilled nursing facility*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
We cover: • 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	In or Out of Network: 20% of charges after in-network deductible

Section 5(d). Emergency services/accidents

Important things you should 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 Cost for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- For Standard Option. For Network Expenses: The calendar year deductible is $1,000 for persons enrolled for Self Only coverage and $2,000 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage and $4,000 for families enrolled for Self and Family coverage. The calendar year deductible applies to almost all Standard Option benefits in this Section. We added "deductible does not apply" to show when the calendar year deductible does not apply.

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 or 1-800-551-0859 (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	
For Standard Option, a calendar year deductible applies to almost all benefits in this Section. We specify when it does not apply.		
Emergency care within our service area	**High Option**	**Standard Option**
We cover: • Emergency and urgently needed care at a doctor's office • Emergency and urgently needed care at an urgent care clinic	$45 per office visit	In Network: $0 for the first 3 office, convenience clinic, telephone, and urgent care visits and evisits combined in calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services are included; however, charges for day treatment services, group visits, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance.

Emergency care within our service area - continued on next page

Benefit Description	You Pay	
Emergency care within our service area (cont.)	**High Option**	**Standard Option**
• Emergency and urgently needed care as an outpatient in a hospital, including doctors' services	$100 per visit	20% of charges after in-network deductible
• Emergency and urgently needed inpatient hospital services	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	20% of charges after in-network deductible
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency care outside our service area	**High Option**	**Standard Option**
We cover: • Emergency and urgently needed care at a doctor's office • Emergency and urgently needed care at an urgent care clinic	$45 per office visit	$0 for the first 3 office, convenience clinic, telephone, and urgent care visits and evisits combined in calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services are included; however, charges for day treatment services, group visits, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance.
• Emergency and urgently needed care as an outpatient in a hospital, including doctors' services	$100 per visit	20% of charges after in-network deductible
• Emergency and urgently needed inpatient hospital services	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of charges	20% of charges after in-network deductible
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*	*All charges*

Benefit Description	You Pay	
Ambulance	**High Option**	**Standard Option**
We cover professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service	20% of charges	In Network: 20% of charges Out of Network: 40% of charges

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

Important things you should 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.
- **You do not need a referral** from your primary care physician to obtain mental health or substance abuse services.
- Our Behavioral Health Personalized Assistance Line (PAL) staff can match you with a network provider who can meet your behavioral health needs. We can identify providers by specialty and by specific diagnostic, language and cultural competence. If you have an urgent need, we can link you to same day/next day psychiatric appointments. Call 952-883-5811 or 1-888-638-8787.
- **YOU MUST GET PRIOR AUTHORIZATION FOR THESE SERVICES.** Refer to section 3 to be sure which services require prior authorization.
- The calendar year deductible, or for facility care, the inpatient deductible, applies to almost all benefits in this section. We added "no deductible" to show when a deductible does not apply.
- For Standard Option. For Network Expenses: The calendar year deductible is $1,000 for persons enrolled for Self Only coverage and $2,000 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage and $4,000 for families enrolled for Self and Family coverage.
- For outpatient chemical health services, we cover supervised lodging at a contracted organization for members actively involved in an affiliated licensed chemical dependency day treatment or intensive outpatient program for treatment of alcohol or drug abuse.
- Be sure to read Section 4, *Your Cost for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
For Standard Option, a calendar year deductible applies to almost all benefits in this Section. We specify when it does not apply.		
Professional services	**High Option**	**Standard Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. 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 illnesses or conditions	Your cost sharing responsibilities are no greater than for other illnesses or conditions

Professional services - continued on next page

Benefit Description	You Pay	
Professional services (cont.)	**High Option**	**Standard Option**
We cover diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$25 per visit	In Network: $0 for the first 3 office, convenience clinic, telephone, and urgent care visits and evisits combined in calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services are included; however, charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance. Out of Network: 40% of charges after out-of-network deductible
Group therapy visits for mental health	$12.50 per visit	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Diagnostics	**High Option**	**Standard Option**
We cover: • Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	10% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
We cover inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$500 annual copayment for inpatient and outpatient hospital services combined, then 10% of inpatient hospital charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible

Benefit Description	You Pay	
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
We cover outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$25 per visit	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Not covered	**High Option**	**Standard Option**
• Services that are not part of a pre-authorized approved treatment plan 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*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- Be sure to read Section 4, *Your Cost for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- For Standard Option. For Network Expenses: The calendar year deductible is $1,000 for persons enrolled for Self Only coverage and $2,000 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage and $4,000 for families enrolled for Self and Family coverage. The deductible does not apply to generic preferred drugs. The deductible does apply to brand and specialty drugs. We added "deductible does not apply" to show when the calendar year deductible does not apply.
- The Plan uses the *Generics Plus Rx Formulary.* It covers fewer brand-name drugs at the preferred brand level. It excludes drugs for sexual dysfunction, acid reflux, stomach ulcers, and oral antihistamines.

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

- **Who can write your prescription.** A licensed provider must write the prescription.
- **Where you can obtain them.**
  - **High Option:** You must fill the prescription at a Plan pharmacy or by mail.
  - **Standard Options:** For in-network benefits, you must fill the prescription at a Plan pharmacy or by mail. Out-of-network benefits apply when you do not use a Plan pharmacy.
  - **For both Options, specialty drugs** must be obtained at a designated vendor. The specialty drug list is available by calling Member Services or by visiting our website at www.healthpartners.com/fehb.
- The plan uses the **Generics Plus Rx formulary**. Check to see which drugs are covered and the level of coverage. The formulary excludes drugs for sexual dysfunction, acid reflux, stomach ulcers, and oral antihistamines.
- **We cover preferred and non-preferred drugs.** Preferred drugs are a 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 prepackaged dispensing unit (but not less than your physician's recommendation of a 30-day supply), or portion thereof, except as follows:
  - **For mail order drugs**, see benefit described below.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand through a prior authorization submission, and that request is approved. Other formulary limitations, such as quantity limits, may still apply. If your physician does not require a brand name drug or we do not approve the request, you have to pay your applicable copay or coinsurance plus the difference in cost between the name brand drug and the generic.
- **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 that 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.

A member who is called to active military duty can call HealthPartners Member Services Department at 952-883-5000 or 1-800-883-2177 to get information on how to get a medium-term supply of drugs.

In the event of a national or other emergency, you can call HealthPartners Member Services Department at 952-883-5000 or 1-800-883-2177 to get information on how to get a supply of drugs to meet your needs.

Benefit Description	You Pay	
For Standard Option, a calendar year deductible applies to almost all benefits in this Section. The deductible does not apply to generic preferred drugs.		
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a licensed provider 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, except those listed as *Not covered.*	$12 copay for generic preferred drugs $45 copay for brand-name preferred drugs $90 copay for non-preferred drugs The copay applies per 30-day supply, or portion thereof	In Network: $9 copay for generic preferred drugs (deductible does not apply) $40 copay for brand-name preferred drugs after deductible $70 copay for non-preferred drugs after deductible The copay applies per 30-day supply, or portion thereof Out of Network: 40% of charges after out-of-network deductible
We cover women's contraceptive drugs,devices, and the morning after pill. Note: Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing for generic preferred drugs All charges for non-preferred drugs	In Network: Nothing for generic preferred drugs All charges for non-preferred drugs Out of Network: 40% of charges after out-of-network deductible
We cover physician prescribed over-the-counter and prescription drugs for tobacco cessation, no limit Note: Over-the-counter or prescription drugs approved by the FDA to treat tobacco dependence are covered under the tobacco cessation benefit. (See page 41.)	Nothing	Nothing
We cover specialty drugs.	20% coinsurance for specialty drugs	In Network: 25% coinsurance for specialty drugs, after in-network deductible Out of Network: *All charges*

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Note: Specialty drugs are injectable and oral medications that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/AIDS. Please refer to the drug plan formulary to determine if the drug you have been prescribed by your physician needs to be filled by one of the plan's Specialty Pharmacy providers. • For safety, all mailing will be shipped based on temperature requirements and considerations. • Specialty drugs cannot be obtained through the traditional 90-day mail order program.	20% coinsurance for specialty drugs	In Network: 25% coinsurance for specialty drugs, after in-network deductible Out of Network: *All 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 . We cover Vitamin D for adults 65 and older* • *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* • *Sexual dysfunction drugs* • *Drugs used for acid reflux and stomach ulcers* • *Oral antihistamines* • *Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft*	*All charges*	*All charges*
Mail order benefits	**High Option**	**Standard Option**
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 1-888-356-6656. This benefit does not apply to drugs listed under Limited Benefits below.	$24 copay for generic preferred drugs $90 copay for brand-name preferred drugs $180 copay for non-preferred drugs The copay applies per 90-day supply, or portion thereof	In Network: $18 copay for generic preferred drugs (deductible does not apply) $80 copay for brand-name preferred drugs after deductible $140 copay for non-preferred drugs after deductible The copay applies per 90-day supply, or portion thereof Out of Network: 40% of charges after out-of-network deductible

Benefit Description	You Pay	
Prescription drug benefits - limited benefits	**High Option**	**Standard Option**
We cover: • Injectable, implantable contraceptive drugs or devices (such as Depo Provera, Norplant, IUDs) (This benefit applies whether the birth control drug or device is used for birth control or for a medically necessary purpose other than birth control) • Contraceptive barrier devices.	Nothing	In Network: Nothing Out of Network: 40% of charges after out-of-network deductible
Growth hormones	20% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
Drugs for treatment of infertility (limited to products listed on the Infertility Products List)	20% of charges and all charges beyond $3,000 calendar year limit	In Network: 20% of charges after in-network deductible, and all charges beyond $3,000 calendar year limit (combined for In Network and Out of Network) Out of Network: 40% of charges after out-of-network deductible, and all charges beyond $3,000 calendar year limit (combined for In Network and Out of Network)

Section 5(g). Dental benefits

Important things you should 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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*.
- For in-network benefits, Plan dentists must provide your care.
- For High Option, there is a $50 calendar year deductible for emergency accidental dental services provided by non-Plan dentists.
- For Standard Option, For Network Expenses: The calendar year deductible is $1,000 for persons enrolled for Self Only coverage and $2,000 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage and $4,000 for families enrolled for Self and Family coverage.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient or as required for children who receive anesthesia per our medical policy. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your Cost for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
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 of injury are covered.	20% of charges	In Network: 20% of charges after in-network deductible Out of Network: 40% of charges after out-of-network deductible
• Emergency dental services for accidental injury, as described above, when they are provided by dentists outside the service area if the injuries 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	20% of the charges after in-network deductible, up to a maximum benefit of $300 per calendar year, and any charges thereafter

Benefit Description	You Pay	
Dental benefit	**High Option**	**Standard Option**
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	*All charges*
Not covered: other dental services not shown as covered	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
CareLine® Service	When you call the CareLine service, 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. The BabyLine service 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.
Behavioral Health Personalized Assistance Line	Our Behavioral Health Personalized Assistance Line (PAL) staff can match you with the network provider that best meets your behavioral health needs. We can identify providers based on: • Specialty or subspecialty • Specific diagnostic, language and cultural competence And if you have an urgent need, we can link you to same day/next day psychiatric appointments. Call 952-883-5811 or 1-888-638-8787.
Nurse Navigators	Nurse Navigators are experienced nurses who can help research treatment options, coordinate care and guide you through difficult decisions. Call 952-883-5000 or 1-800-883-2177.
Services for the 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 CareLineService: 952-883-5474 BabyLine Service: 952-883-5474
Online tools	As a Plan member, you have instant access to detailed, secured information and helpful services tailored to you. Depending on your coverage, you may be able to: • View your personal health record • See your claims information • View your benefits • View your medical and dental provider networks • Find health and wellness information • Order new ID cards • Make appointments at HealthPartners Clinics • Refill a mail order prescription or a prescription at a HealthPartners Clinic • Determine the retail and mail order costs of specific drugs • See all the medications on the HealthPartners preferred list of covered drugs • Estimate your annual cost of medical care To access your personalized member page, visit www.healthpartners.com/fehb.
virtuwell™	virtuwell™ is an online clinic that treats everyday illnesses so you- or your kids-can get better. • Quickly and conveniently get care for over 40 common conditions

- get a diagnosis, treatment plan and prescription if needed- all in less than an hour
- you pay nothing for the first three visits per person in a calendar year. See section 5(a)
- 24/7, with nurse practitioners available

Mobile tools

Download the HealthPartners iPhone app or visit the mobile site to find and manage your health plan on-the-go.

Use your smartphone to:

- Access your Member ID card
- Check your plan balances including your deductible
- Search for the closest care locations to you

Download the app today in the iTunes app store or visit **m.healthpartners.com** to learn more about HealthPartners mobile offerings, visit **healthpartners.com/gomobile.**

If you have a mobile phone that can get text messages, you can receive a variety of texts from HealthPartners. Either opt in to receive weekly texts or add a phone number in your myHealthPartners account to get text specific to you.

Text one of these commands to 77199:

- **DED**: For how much is remaining until you meet your deductible
- **YUM**: For better-for-you eating tips from yumPower
- **FAMILY**: For ideas to support your family's health
- **QUITNOW**: For tips to help you quit smoking

Health assessment and wellness courses

Get rewarded in 3 **simple steps.**

- Take your health assessment by logging into your *my*HealthPartners account at www.healthpartners.com/fehb. If you don't have a username and password, click on "sign up for *my*HealthPartners.
- Sign up for a well-being activity.
- Complete the assessment and an activity. Don’t forget, this includes your spouse, domestic partner or one covered dependent over 18!

There’s no greater reward than living a healthy life. In case you need extra incentive, we've got one for you. You can earn up to $150 in a HealthPartners MasterCard ® prepaid rewards card when both you and your covered spouse, domestic partner or adult dependent complete the assessment and an activity.

Flexible benefits option

Under the flexible benefits option, we determine the most effective way to provide services.

- We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue.
- Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process.
- By approving an alternative benefit, we do not guarantee you will get it in the future.
- The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits.

- If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request.

Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).

Section 5(i). Non-FEHB benefits available to Plan members

The benefits listed in this section are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow the Plan's guidelines. For additional information contact the Plan at 952-883-5000 or 1-800-883-2177 (hearing impaired individuals should call 952-883-5127) or visit www.healthpartners.com/fehb.

Medicare Plan Enrollment – Applicable to High Option only (not applicable to Standard Option)

High Option offers Medicare recipients the opportunity to dually enroll in a HealthPartners Freedom Medicare plan at no additional FEHBP or HealthPartners premium. Contact us at 952-883-5600 for information on the Freedom Medicare plan. Note that as indicated on page 74, 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.

For both High Option and Standard Option, HealthPartners is proud to offer value-added services that help members lead healthier lifestyles.

Eyewear discount	You may be eligible for an eyewear discount at Plan optical centers, including HealthPartners Eye Care Centers and EyeMed retailers such as Target, LensCrafters, etc. For more information on the program visit www.healthpartners.com/fehb or call member services at 1-800-883-2177.
Frequent Fitness Program	You may be eligible for the Plan's Frequent Fitness program, which reimburses up to $20 for members who register and work out 12 or more times per month at participating fitness clubs. Maximum reimbursement is $40 per household per month and other important guides apply. For more information on the program visit www.healthpartners.com/fehb or call member services at 1-800-883-2177.
Healthy discounts program	HealthPartners retail savings program gives you discounts on tools and services from reputable organizations to help you be as healthy as you can be. Complete information and list of partner organizations can be found online at www.healthpartners.com/fehb or call member services at 1-800-883-2177

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies 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 (see specifics regarding transplants)
- 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
- 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
- Marriage counseling services

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance or deductible.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 952-883-5000 or 1-800-883-2177 (TTY 952-883-5127), or at our website at www.healthpartners.com/fehb.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS -1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

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

Prescription drugs

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

Other supplies or 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.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call us at 952-883-5000 or 800-883-2177 or visit our website at www.healthpartners.com/fehb.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing HealthPartners Claims, P.O. Box 1289, Minneapolis, MN 55440-1289 or calling 952-883-5000 or 1-800-883-2177 (TTY 953-883-5127).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

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. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information 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.
3	If you do not agree with the 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: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E Street NW, Washington, DC 20415-3620. 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 • Your daytime phone number and the best time to call • Your email address if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. 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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	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 you did not indicate that your claim was a claim for urgent care, then call us at 952-883-5000 or 1-800-883-2177. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC web site at http://www.NAIC.org.

For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC web site at When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay the lesser of our allowance and the difference between our allowance and what is paid by the primary plan, minus any copayments or coinsurance required on our plan. If our plan includes coinsurance, it will be applied to the remaining charges not paid by the primary plan. In the following example, the other plan is primary and our plan is secondary. Our plan requires the member to pay 10% coinsurance.

DOS2-2-2012 billed	$10,000
Primary plan allowance	9,000
Primary plan payment (80% of allowance)	7,200
Balance after primary plan payment	1,800
Member pays ($1,800 x 10%)	180
Our plan pays ($1,800 x 90%)	$1,620

- 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 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 TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) 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.

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

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or 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 four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227) (TTY 1-800-325-0778) 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about our prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something about filing your claims, call us at 952-883-5000 or 1-800-883-2177 (TTY 952-883-5127) or see our website at www.healthpartners.com/fehb.

We do not waive any costs if the Original Medicare Plan is your primary payor.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) or at www.medicare.gov or call us at 952-883-5000 or 1-800-883-2177 (TTY 952-883-5127) or see our Web site at www.healthpartners.com/fehb.

If you enroll in a Medicare Advantage plan, the following options are available to you. **Applicable to the High Option and our Freedom Medicare Plans (not available if you are enrolled in the Standard Option):** You may enroll in our Freedom Medicare Plan and remain enrolled in our FEHB Plan.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage 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 Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

• **Medicare prescription drug coverage (Part D)**	When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

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.

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application review by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 22.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 22.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

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 22.

Experimental or investigational service

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.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

This plan defines medically necessary care as care that is appropriate for the condition, including those related to mental health. It includes the kind and level of service. It includes the number of treatments. It also includes where you get the service and how long it continues. Medically necessary care must:

- Be the service that other providers would usually order
- Help you get better, or stay as well as you are
- Help stop the condition from getting worse
- Help prevent and find health problems

Plan allowance

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

- For covered services delivered by Plan providers, or Plan referral providers, our allowance is the provider's discounted charge for a given medical/surgical service, procedure or item, which Plan providers have agreed to accept as payment in full.
- For covered services delivered by non-Plan providers, our allowance is the provider's charge for a given medical/surgical service, procedure or item, according to the usual and customary charge amount.
- The Usual and Customary Charge is the maximum amount allowed we consider in the calculation and payment of charges incurred for certain covered services. It is consistent with the charges of other providers of a given service or item in the same region.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Us/We

Us and we have the same meaning as HealthPartners and its related organizations.

You

You refers to the enrollee and each covered family member.

Urgent care claims

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve pre-service claims and post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our customer service department. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, and **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26), which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA) –** Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call a FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental. **This program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures
- Class D (Orthodontic) services with up to a 12-month waiting period. Beginning in 2014, most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.tcfeds.com.

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

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Summary of benefits for 2014 High Option

- **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.

High Option	You pay	Page
Medical services provided by physicians: • **Diagnostic and treatment services provided in the office**	$10 per convenience clinic visit; $25 per office visit for primary care; $45 per specialist visit; $45 per urgent care visit; $0 for first three virtuwell $10 per virtuwell evisits per person	27
Services provided by a hospital: • **Inpatient**	$500 annual copay for inpatient & outpatient combined, then 10% of charges	50
• **Outpatient**	$500 annual copay for inpatient & outpatient combined, then 10% of charges	51
Emergency benefits: • **In-area**	$100 per emergency room visit; $45 per office or urgent care center visit	54
• **Out-of-area**	$100 per emergency room visits; $45 per office or urgent care center visit	55
Mental health and substance abuse treatment	Regular cost sharing	57
Prescription drugs: • **Retail pharmacy (generally a 30-day supply)**	$12 copay for generic preferred drugs $45 copay for brand-name preferred drugs $90 copay for non-preferred drugs	60
• **Mail order service (generally a 90-day supply)**	$24 copay for generic preferred drugs $90 copay for brand-name preferred drugs $180 copay for non-preferred drugs	62
Dental care: • **Accidental injury**	20% of charges, if Plan dentist provides care	64
• **Preventive dental**	Nothing	65
Vision care	Nothing for preventive care	36
Special features: CareLine® service, Nurse Navigator, Behavioral Health Personalized Assistance Line, special phone lines for deaf and hearing impaired, personalized member page on Web site, health improvement programs		66
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after $4,000/Self only or $8,000/Family per calendar year	22

Summary of benefits for 2014 Standard Option

- **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.

Standard Option	You Pay	Page
Medical services provided by physicians: • **Diagnostic and treatment services provided in the office, urgent care and convenience clinic and by evisit and telephone**	In Network: $0 for 3 visits, then 20% after deductible Out of Network: 40% after deductible $0 for first 3 virtuwell evisits per person, then 20% after deductible	27
Services provided by a hospital: • **Inpatient**	In Network: 20% after deductible Out of Network: 40% after deductible	50
• **Outpatient**	In Network: 20% after deductible Out of Network: 40% after deductible	51
Emergency out-patient hospital benefits: • **In-area**	20% after in-network deductible	54
• **Out-of-area**	20% after in-network deductible	55
Mental health and substance abuse treatment	Regular cost sharing	57
Prescription drugs: • **Retail pharmacy (generally a 30-day supply)**	In Network copay: $9 for generic preferred drugs; $40 for brand preferred drugs after deductible; $70 for non-preferred drugs after deductible; 25% for specialty drugs after deductible. Out of Network: 40% after deductible.	60
• **Mail order service (generally a 90-day supply)**	In Network copay: $18 for generic preferred drugs; $80 for brand preferred drugs after deductible; $140 for non-preferred drugs after deductible. Out of Network: 40% after deductible.	62
Dental care: • **Accidental injury**	In Network: 20% after deductible. Out of Network: 40% after deductible.	64
• **Preventive dental**	All charges	65
Vision care	Nothing for preventive care	36
Special features: CareLine® service, Nurse Navigator, Behavioral Health Personalized Assistance Line, special phone lines for deaf and hearing impaired, personalized member page on Web site, health improvement programs		66
Protection against catastrophic costs (out-of-pocket maximum)	In Network: Nothing after $5,000/Self only or $10,000/Family per calendar year Out of Network: no maximum	22

Notes

2014 Rate Information

For 2014 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.