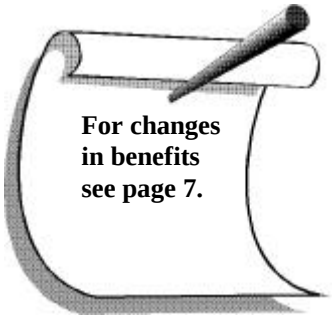
Western Health Advantage

http://www.westernhealth.com

2001

A Health Maintenance Organization



Serving: Portions of Northern California

Enrollment in this Plan is limited; see page 6 for requirements.

This Plan has " New Plan" accreditation from the NCQA. See the 2001 Guide for more information on NCQA

Enrollment codes for this Plan:

5Z1 Self Only
5Z2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees
Health Benefits Program

RI 73 -780

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Introduction

Western Health Advantage
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773

This brochure describes the benefits of Western Health Advantage (WHA) under our contract (CS 2840) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Western Health Advantage, (WHA).

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

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

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

How we pay providers

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

Who provides my health care

Our plan doctors treat patients in a group practice arrangement at multiple convenient locations near your home or office. WHA features some of the region's premiere medical professionals, giving our members access to more than 500 primary care doctors and more than 1100 specialty physicians. Each member of your family can choose their own primary care doctor. He/she is responsible for coordinating your health care with specialists and other medical providers. To give you more flexibility in choosing specialty care, WHA offers you access to all the specialty physicians in the network, not just those who are affiliated with your primary care doctor's medical group.

When you enroll, you will be asked to let the Plan know which primary care physician (s) you've selected for you and each member of your family by sending a Primary Care Designation form to the Plan. If you need help choosing a doctor, call the Plan. Members may change their doctor selection monthly by notifying the Plan 30 days in advance. Each member of the family may choose their own primary care doctor from the complete list of participating primary care physicians. Your Primary Care doctor will make arrangements for you to seek specialty care when the need arises. Women can self-refer to participating OB/Gyn doctors whenever they need these services without a referral, and everyone can self-refer for an annual eye exam to one of the participating eye specialists.

WHA wants you to receive the care you need, when you need it. In most cases your primary care doctor will be available for urgent visits. When that is not possible, we also offer a unique program, which ensures access to another primary care doctor for acute medical needs within one working day. Please call your primary care doctor's office when you have an urgent situation and need to see a doctor.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Western Health Advantage is a full service, not-for-profit health care plan operating in Sacramento, Yolo, and portions of Placer, Solano, and El Dorado Counties.

- Western Health Advantage was created by local health care providers in 1997 who believe health care can be delivered in a managed care environment without sacrificing service and quality.
- Western Health Advantage has been granted "New Health Plan" Accreditation effective December 1, 1999 by NCQA.

If you want more information about us, call 916-563-2250, or write to:

Western Health Advantage
1331 Garden Highway, Suite 100
Sacramento, CA 95833

You may also contact us by fax at 916-563-3182 or visit our website at www.westernhealth.com.

Service Area

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is: all of Sacramento and Yolo County, a portion of Placer County, Western El Dorado County (zip codes shown below) and portions of Solano County (zip codes shown below).

El Dorado County zip codes:

95613, 95614, 95619, 95623, 95633, 95634, 95635, 95636, 95656, 95667, 95672, 95675, 95682, 95684, 95709, 95726, 95762

Solano County zip codes:

94512, 94533, 94535, 94571, 94585, 95620, 95625, 95687, 95688, 95696

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services.

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

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network, will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling Member Services at 1-888-563-2250, or checking our website www.westernhealth.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 14.7% for Self Only or 14.7% for Self and Family.
- The plan now provides coverage for testing and treatment of Phenylketonuria (PKU), which includes the cost of any special foods or formula over and above a "regular diet," subject to the $10 office visit copay (See page 16).
- Care in a Skilled Nursing Facility is now covered at 100% with no day limit. Previously, care in a Skilled Nursing Facility was covered at 100% for up to 100 days per calendar year (See page 28).

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 916-563-2250 or 1-888-563-2250

Where you get covered care

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

· Plan providers

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our website www.westernhealth.com.

· Plan facilities

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. You may designate a different primary care physician for each member if you wish. This decision is important since your primary care physician provides or arranges for most of your health care.

If you have never been seen by the primary care physician you choose, please call his or her office before designating him or her as your primary care physician. Not only are some practices temporarily closed because they are full, but this also gives the office the opportunity to explain any new patient requirements.

The name of your primary care physician will appear on your WHA identification card. If you do not designate a primary care physician at the time of enrollment, WHA will assign one to you.

· Primary care

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

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

· **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, women can self-refer to participating OB/GYN doctors whenever they need these services, without a referral, and everyone can self-refer for an annual eye exam to one of the participating eye specialists.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan. The treatment plan will permit you to visit your specialist without the need to obtain further referrals.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  •• terminate our contract with your specialist for other than cause; or

  •• drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  •• reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 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 90 days.

· **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 916-563-2250 or 1-888-563-2250. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the hospital benefit of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process Prior Authorization. Your physician must obtain prior authorization before sending you to a hospital, referring you to a specialist, or recommending follow-up care.

Any prior authorization is conditioned upon the member being duly enrolled at the time the covered services are received. If WHA denies authorization, and the member goes ahead and obtains the service anyway, the member will be responsible for the cost of any services not authorized by WHA. Additionally, if the member is not duly enrolled or if such authorized services are provided after the date the member's enrollment ceased, the member will reimburse WHA, if necessary.

Your WHA ID card alerts your provider that you are a WHA member and that certain services will require prior authorization when needed. Your physician will receive written notice of authorized or denied services and you will be notified of any denials. Please direct your questions about prior authorization to your primary care physician.

An example of procedures and services that need prior authorization are:

- Any provider not listed in WHA's provider directory is a non-participating provider and you must obtain prior authorization from WHA before obtaining services.
- All second opinions performed by non-participating providers require prior authorization from WHA or its delegated medical group.
- Some outpatient services, such as diagnostic testing, X-rays, and surgical procedures require prior authorization.
- All inpatient hospitalization requires prior authorization, except in an emergency situation.
- Hospice services are covered with prior authorization.
- Infertility services are covered including testing, consultations, examinations, diagnostic surgical services related to hospitalizations

or facilities, and drug therapy. Services are covered when obtained with prior authorization.

- Chiropractic care for spinal manipulation only, for conditions, causing headache, or neck and back pain, (when traditional therapies have been ineffective), when obtained from participating providers upon referral from primary care physician and with prior authorization.
- Acupuncture for pain management services only, (when traditional therapies have been ineffective), when obtained from participating providers upon referral from primary care physician and with prior authorization.
- Non-emergency medical transport inside or outside the service area, except with prior authorization.
- Medically necessary services as determined by WHA, for the treatment of morbid obesity with a prior authorization.

Section 4. Your costs for covered services

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

- **Copayments** — A copayment is a fixed amount of money you pay to the provider when you receive services.

  Example: When you see your primary care physician you pay a copayment of $10 per office visit.

- **Deductible** — We do not have a deductible.

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

- **Coinsurance** — Coinsurance is the percentage of our allowance that you must pay for your care.

  Example: In our Plan, you pay 50% of our allowance for infertility services, and 20% of our allowance for orthopedic devices, prosthetic devices, and durable medical equipment.

Your out-of-pocket maximum for copayments and coinsurance

After your copayments and coinsurance total $750 per person or $1,500 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services: prescription drugs, durable medical equipment, prosthetic devices and orthotic devices..

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

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 53 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at *1-888-563-2250* or at our website at www.westernhealth.com.

(a) Medical services and supplies provided by physicians and other health care professionals……14-21

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Rehabilitative therapies
- Hearing services (testing, treatment, and supplies)
- Vision services (testing, treatment, and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Alternative treatments
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals 22-25

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services 26-27

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents 28-29

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits 30-31

(f) Prescription drug benefits 32-35

(g) Special features 36

- Advantage Referral Program

(h) Dental benefits 37

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

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • Plan physicians must provide or arrange your care. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	Nothing
• Office medical consultation • Second surgical opinion	$10 per office visit
• At home	$10 per office visit

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	
Routine screenings, such as: • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including ••Fecal occult blood test	$10 per office visit, no charge if performed at laboratory only.
••Sigmoidoscopy, screening – every five years starting at age 50	$10 per office visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office visit, no charge if performed at laboratory only.
Routine pap test	$10 per office visit, no charge for test.
Preventive care, adult	**You pay**
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 and over, one every calendar year	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing for immunizations, office visit copay may apply.
Preventive care, children	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing

Preventive care, children *(Continued)*	**You pay**
• Examinations, such as: ••Eye exams, all ages ••Ear exams, all ages	$10 per office visit
• Well baby care (birth to two years)	Nothing
• Testing and treatment of Phenylketonuria (PKU), which includes the cost of any special foods or formula over and above a "regular diet"	$10 per office visit
Maternity care	**You pay**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to preauthorize your normal delivery; see page 27 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*

Family planning	You pay
• Voluntary sterilization	$10 per office visit
• Surgically implanted contraceptives	$200 copayment for Norplant and other implanted time-release contraceptives.
• Injectable contraceptive drugs	$10 per office visit.
• Intrauterine devices (IUDs)	$10 per office visit.
Not covered: reversal of voluntary surgical sterilization, genetic counseling.	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as:	50% of the charges
• Artificial insemination:	
••*intravaginal insemination (IVI)*	
••*intracervical insemination (ICI)*	
••*intrauterine insemination (IUI)*	
• Fertility drugs	50% of charges
Services may include one gamete interfallopian transfer ("GIFT") or one in-vitro fertilization (IVF) but only one of these procedures is covered per Lifetime.	50% of charges
Not covered:	
• *Assisted reproductive technology (ART) procedures, such as:*	*All charges.*
• *embryo transfer*	
• *Services and supplies related to excluded ART procedures*	
• *Cost of donor sperm*	
Allergy care	
Testing and treatment	$10 per office visit
Allergy injection	$10 per office visit
Allergy serum	Nothing

Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	**You pay**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 24. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT)	Nothing
Rehabilitative therapies	**You pay**
Physical therapy, occupational therapy and speech therapy -- ••qualified physical therapists; ••speech therapists; and ••occupational therapists. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions	$10 per office visit $10 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for all ages.	$10 per office visit $10 per office visit
Not covered: • *hearing aids, testing and examinations for them, except when necessitated by accidental injury* • *hearing aid batteries.*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
Annual eye exams	$10 per office visit
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per office visit
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care)	$10 per office visit
• Annual eye refractions	$10 per office visit
Not covered: • *Eyeglasses, contacts,lenses or frames* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery.*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose	20% of charges
• Leg and knee braces; foot orthotics when medically necessary	20% of charges
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy	20% of charges
• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device.	
• Penile Prostheses which are medically necessary secondary to trauma, tumor, or physical disease to the circulatory system or nerve supply and are not of a psychological cause.	50% of charges
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	20% of charges
Orthopedic and prosthetic devices *(Continued)*	**You pay**
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics when not medically necessary* • *heel pads and heel cups* • *back braces or other lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen, oxygen equipment and dialysis equipment. Under this benefit, we also cover: • hospital beds; • standard wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps.	20% of charges

Not covered: • *Motorized wheelchairs*	*All charges.*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing

Home health services *(Continued)*	**You pay**
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Alternative treatments	
• Acupuncture – by a doctor of medicine or osteopathy for: pain relief when traditional therapies have been ineffective. Services must be obtained by referral from your primary care doctor and obtained from a participating plan provider. Up to 20 visits per calendar year are covered with prior authorization.	$15 per office visit
• Chiropractic care for spinal manipulation only, for conditions causing headache, or neck and back pain, when traditional therapies have been ineffective. Services must be obtained by referral from your primary care doctor and obtained from a participating plan provider. Up to 20 visits per calendar year are covered with prior authorization.	$15 per office visit
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges.*
Educational classes and programs	**You Pay**
Coverage is limited to: Smoking Cessation-Nicotine transdermal systems, such as Habitrol or Nicoderm are covered as a "Wellness Benefit". You must obtain a prescription from your primary care physician. One 10-week treatment will be covered per member under any current or future WHA contract.	100% of the cost of the medication, initially. Upon remaining smoke free for 90 days after treatment, as certified by your physician, WHA will reimburse you in full. You must be an active participant in WHA at the time of the reimbursement. Reimbursement should be requested within 60 days of certification.
• Diabetes self-management	$10 per office visit

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5 (c) for charges associated with the facility charge (i.e. hospital, surgical center, etc.) are covered in Section 5 (c).
- YOUR PLAN DOCTOR MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information.	$10 per office visit

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
• Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit $10 per office visit $10 per office visit
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	**You pay**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	Nothing
• All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing 20% of charges
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*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per visit if in physician's office.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), including any dental care involved in the treatment of temporomandibulor joint (TMJ) pain dysfunction sysdrome.*	*All charges*
Organ/tissue transplants	**You pay**
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

Here are some important things to remember about these benefits:

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

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. 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, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing

Inpatient hospital *(Continued)*	**You pay**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	**You pay**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	**You pay**
The Plan provides a comprehensive range of benefits with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor.	Nothing
Not covered: custodial care	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services include inpatient and outpatient care, and family counseling. These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate.	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

Emergency Services and Care also pertain to:

- Psychiatric screening, examination, evaluation, and treatment by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges.
- Care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capability of a facility.

What to do in case of emergency:

Emergencies within the service area:

In emergencies, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified in a timely manner.

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

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

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

Emergency services/accidents *(Continued)*

Emergencies outside the service area:

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

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

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

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center	$15 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services.	$50 per visit (copay is waived if admitted to a hospital)
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center	$15 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit (copay is waived if admitted to a hospital)
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges.*
Ambulance	**You pay**
• Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing
• Air Ambulance when medically necessary.	Nothing

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

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR PLAN DOCTOR MUST GET PRIOR AUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers. • Medication management	$10 per office visit

Mental health and substance abuse benefits—Continued on next page

Mental health and substance abuse benefits *(Continued)*	
Benefit Description	**You pay**
• Diagnostic Tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes. These include:

- Your primary care physician will refer you to the most appropriate level of care.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation

We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

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

IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy, or by mail if the prescription is for maintenance medications, which are to be taken beyond 60 days. The Plan's Member Services department will have additional "Prescription by Mail" brochures available if you need them.
- **We use a formulary. The "Three Tier Co-Pay Plan"** means there is not a closed formulary, but three different copays. All generic medications are covered at the lowest copay; brand name medications on the formulary, i.e., Preferred Drug List (PDL) have the middle level copay; and brand name medications not on the formulary, i.e., PDL have the highest copay. However, in all three categories a number of the drugs may need prior authorization to ensure the appropriate use of the drug. Members may request a copy of the PDL by calling 1-888-563-2250 or view the document on the web page: www.westernhealth.com.

- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. **You pay** a $5 copay per prescription unit or refill for generic drugs or $10 copay per prescription unit or refill for name brand drugs on the formulary, i.e., Preferred Drug List (PDL); and a $20 copay per prescription unit or refill for Non-Preferred (non-formulary) name brand medications per each 30-day supply or 120-unit supply, whichever is less. In no event will the copay exceed the cost of the prescription drug. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and name brand drug as well as the $10 copay per prescription unit or refill. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's formulary policy. Non-formulary drugs will be covered when prescribed by a Plan doctor.

  Covered prescription medications that are to be taken beyond 60 days are considered maintenance medications. Maintenance medications are used in the treatment of chronic conditions like arthritis, high blood pressure, heart conditions, and diabetes. Oral contraceptives are also available through the mail order program. Maintenance medications may be obtained through Western Health Advantage's Mail Order Program. You can request the order form and brochure for this benefit by contacting WHA's Member Service Department at 1-888-563-2250. The initial prescription for maintenance medications is dispensed through a participating pharmacy (limited to a 30-day supply). Subsequent refills for a 90-day supply may be obtained through the Mail Order Program. You pay a $10 copay for a 90-day supply of generic medication, a $20 copay for a 90-day supply of brand name medication on the formulary, i.e., Preferred Drug List (PDL); and a $40 copay for a 90- day supply of brand name medication which is Non-Preferred (non-formulary) through the Mail Order Program. In this way, you receive a 90-day supply of medication for only two copays.

  When you have to file a claim. If you have to pay for a covered prescription, you may submit your receipt, along with a note explaining the situation to our Member Services Department, and you will be reimbursed by the Plan for the cost of the medication, less the applicable copay.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by state or Federal law of the United States, require a physician's prescription for their purchase, except as excluded below. • Insulin with a copay charge applied to each vial • Disposable needles and syringes for the administration of covered medications • Glucose test tablets and test tape, Benedict's solution or equivalent, and acetone test tablets are covered up to a 30-day supply per copay • Contraceptive drugs and devices including diaphragms • Inhalers (limited to two per prescription) • Prescription prenatal vitamins or vitamins in conjunction with fluoride	$5 per 30-day supply for generic drugs $10 per 30-day supply for formulary, i.e., preferred name brand drugs $20 per 30-day supply for name brand drugs not on the formulary, i.e., Preferred Drug List Note: If there is no generic equivalent available, you will still have to pay the name brand copay
• Drugs for sexual dysfunction. Episodic medications for the treatment of sexual dysfunction are limited to 6 pills per 30-day supply. (see prior authorization below)	50% of charges
• Covered medications dispensed by a non-participating pharmacy outside of WHA's Service Area for Urgent Care or Emergency care only. **Maximum 10 day supply.**	100% (Submit your receipt to WHA within 60 days of purchase and you will be reimbursed the full purchase price less the applicable copayment)
• Nicotine transdermal systems, such as Habitrol or Nicoderm are covered as a "Wellness Benefit." You must obtain a prescription from your primary care physician. **One 10-week treatment will be covered per member under any current or future Western Health Advantage contract.**	100% (Upon remaining smoke-free for 90 days as certified by your primary care physician, Western Health Advantage will reimburse you in full. You must be active with Western Health Advantage at the time of reimbursement. Reimbursement should be requested within 60 days of certification)

Covered medications and supplies *(continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written (DAW) for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs as a lower cost. To order a prescription drug brochure, call 1-888-563-2250.	
Not covered: • *Drugs and supplies for cosmetic purposes;* • *Vitamins, nutrients and food supplements that can be purchased without a prescription (except for special food products that are medically necessary for the treatment of PKU) even if a physician prescribes or administers them;* • *Nonprescription medicines.* • *Medical supplies such as dressings and antiseptics* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Drugs to enhance athletic purposes*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Advantage Referral Program	In order to expand the choice of specialists, WHA has implemented a unique program, the Advantage Referral Program, which allows you to access all specialists in our network rather than just those who have a direct relationship with your primary care physician. Your primary care physician will treat most of your health care needs. If he or she determines that your medical condition requires specialty care, you will be referred to an appropriate provider. You may, however, request to be referred to any of the WHA network specialists. In most cases, you will be comfortable with the specialist that your primary care physician selects; however, if you already have a relationship with a network specialist, or prefer another network specialist, you may ask to be referred to him or her instead. The provider directory lists all of the network specialists approved for referrals by your primary care physician. Self-referred annual well-woman exams, obstetrical services and annual eye exams are included in the Advantage Referral Program and do not require a primary care physician referral or prior authorization, as long as the provider is listed in the WHA provider directory.

Section 5 (h). Dental benefits

IMPORTANT

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

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

IMPORTANT

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing

Dental benefits

We have no other dental benefits.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 10.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

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

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

Medical , hospital and drug benefit

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 916-563-2250 or 1-888-563-2250.

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

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

Submit your claims to:

Western Health Advantage
Attn: Claims Department
1331 Garden Highway, Suite 100
Sacramento, CA 95833-9773

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Western Health Advantage, 1331 Garden Highway, Suite 100, Sacramento, CA 95833-9773 and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or if applicable arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, D.C. 20044-0436.

The Disputed Claims Process *(Continued)*

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 we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, 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 provide a copy of your specific written consent with the review request.

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

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

6 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. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 916-563-2250 or 1-888-563-2250 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202-606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

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

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

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

When a member has available benefits with another health plan or insurance policy, WHA as a secondary payer, will pay only the remaining allowable charges whether or not a claim is made to the primary payer. Duplicate coverage does not reduce member's obligation to make all required copayments.

•What is Medicare?

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

••Some people with disabilities, under 65 years of age.

•• People with End-Stage Renal disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance). Most people pay monthly for Part B.

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

The Original Medicare Plan

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

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your primary care physician. WHA does not duplicate any benefits to which members are entitled under workers' compensation law, employer liability laws, Medicare Part A and B, or CHAMPUS. WHA retains all sums payable under these laws for services provided.

By your enrollment, you agree to submit the necessary documents requested by WHA to assist in recovering the maximum value of services you receive under Medicare, CHAMPUS, the workers' compensation law, or any other health plans or insurance policies.

We will not waive any of our copayments, or coinsurance.

(Primary payer chart begins on next page.)

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

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

Please note, if your Primary Care Physician does not participate in Medicare, you will have to file a claim with Medicare

Claims process – You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 916-563-2250.

Medicare Managed Care Plan

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

This Plan and another Plan's Medicare manage care plan: You may enroll in another plan's Medicare manage care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, or coinsurance.

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

Enrollment in Medicare Part B

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency 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 benefits. You must use our providers.

Medicaid

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

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

In cases of injuries caused by any act or omission of a third party (including, without limitation, motor vehicle accidents and Workers' Compensation cases), WHA will furnish covered services. However, in the event of any recovery from a third party on account of such injuries, the member will reimburse WHA for the value of the services and benefits, as set forth below. By enrolling in this Plan, each member grants WHA a lien on any such recovery and agrees to protect the interests of WHA when there is possibility that a third party may be liable for a member's injuries. Each member specifically agrees as follows:

a) Each member will give prompt notification to WHA of the name and location of the third party, if known, and of the circumstances which caused the injuries; and

b) Each member will execute and deliver to WHA or its nominee any and all lien authorizations, assignments or other documents requested by WHA which may be necessary or appropriate to protect the legal rights of WHA or its nominee fully and completely.

This reimbursement will not exceed the total amount of recovery you obtain. The member may not take any action that might prejudice WHA's subrogation rights.

If you receive a judgment or settle a claim for injury and the judgment or settlement does not specifically include payment for medical costs, WHA will nevertheless have a lien against such recovery for the value of the covered services and benefits at prevailing rates.

If you have a malpractice claim

If you have a malpractice claim because of services you did or did not receive from a plan provider, it must go to binding arbitration. Contact us about how to begin our binding arbitration process.

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.

Copayment

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

Coinsurance

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

Covered services

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

Custodial care

Means care which can be provided by a layperson, which does not require the continuing attention of trained medical or paramedical personnel, and which has no significant relation to treatment of a medical condition.

Experimental or investigational services

In order to determine whether or not a procedure, service, or supply is experimental or investigational, we gather appropriate information for a decision that will be made by medical professionals. The information we collect may include medical records, current reviews of medical literature and scientific evidence, results of current studies or clinical trials, and approvals by regulatory bodies. After reviewing all pertinent information, we make our determination and notify you of the decision.

We will also notify you of the opportunity to request an external review. Your request must be made within 5 business days of the receipt of our denial. A panel of physicians or other providers who are experts in the treatment of your medical condition and knowledgeable about the recommended therapy will do the external independent review. All costs associated with the external review are covered in full and the recommendations of the expert outside reviewers will be followed.

Group health coverage

A policy protecting a specified minimum number of persons usually having the same employer.

Medical necessity

Means that which WHA determines:

- is appropriate and necessary for the diagnosis or treatment of the member's medical condition, in accordance with professionally recognized standards of care;
- is not mainly for the convenience of member or member's physician or other provider; and
- is the most appropriate supply or level of service for the injury or illness.

For hospital admissions, this means that acute care as an inpatient is necessary due to the kind of services the member is receiving, and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

Plan Allowance

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

	portion of the cost is a percentage of the Plan's discounted contract rate and the contract rate is payment in full.
Us/We	Us and we refer to Western Health Advantage (WHA)
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

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.

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

Enrolling in TCC

Get the RI 79-27, which describes TCC, and the RI 70-5, *the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of*

Coverage and Former Spouse Enrollees, from your employing or retirement office or from www.opm.gov/insure.

Converting to individual coverage

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

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

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

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

Getting a Certificate of Group Health Plan Coverage

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.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 916-563-2250 or 1-888-563-2250 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—202-418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

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Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

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Summary of benefits for *Western Health Advantage* – 2001

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	14
Services provided by a hospital: • Inpatient..... • Outpatient	 Nothing Nothing	27 28
Emergency benefits: • In-area..... • Out-of-area.....	 $50 per hospital emergency room $50 per hospital emergency room	29 30
Mental health and substance abuse treatment.....	Regular cost sharing	31
Prescription drugs..... For up to a 30 day supply per prescription unit or refill	$5 copay for generic drugs $10 copay for formulary name brand drugs $20 copay for non-formulary name brand drugs	33
Dental Care …… We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing	37
Vision Care • Annual eye exams • One pair eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam to determine the need for vision correction for children through age 17 • Annual eye refractions	 $10 per office visit $10 per office visit $10 per office visit $10 per office visit	19
Special features: Advantage Referral Program		36
Protection against catastrophic costs	Nothing after $750/Self Only or $1,500/Self and Family enrollment per year Some costs do not count toward this protection	12

2001 Rate Information for
Western Health Advantage

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	5Z1	$67.32	$22.44	$145.86	$48.62	$79.66	$10.10
Self and Family	5Z2	$161.57	$53.85	$350.06	$116.68	$191.19	$24.23