WELBORN HMO

http://www.welbornhealthplans.com

WELBORN HEALTH PLANS

2002

A Health Maintenance Organization

Serving: Southwestern Indiana

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 5 for requirements.

Enrollment codes for this Plan:

H31 Self Only
H32 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 73-430

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Introduction

Welborn HMO
421 Chestnut Street
Evansville, IN 47713

This brochure describes the benefits of Welborn HMO under our contract (CS 2394) 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and are summarized on page 5. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

?? Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means Welborn Health Plans.

?? We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.

?? Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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

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 (812) 426-6600, (800) 521-0265, or TDD/TTY (812) 426-9286 and explain the situation.
?? If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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.

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 and 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.

Your Rights

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

Welborn HMO is a Managed Care Organization locally based and operated by Welborn Clinic, and has been licensed as a for-profit, privately held Health Maintenance Organization (HMO) since September 1, 1986. As a member, you are part of a locally-owned health plan that offers quality, access and value. Welborn HMO has been a recognized innovator and leader in managed health care for the past 16 years.

If you want more information about us, call (812) 426-6600, (800) 521-0265, or TDD/TTY (812) 426-9286, or write to Welborn Health Plans, Member Services Department, 421 Chestnut Street, Evansville IN 47713. You may also contact us by fax at (812) 426-9476 or visit our website at www.welbornhealthplans.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: the Indiana counties of Daviess, Dubois, Gibson, Knox, Perry, Pike, Posey, Spencer, Vanderburgh and Warrick.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. You or a family member must notify us within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that we are notified timely. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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

Section 2. How we change for 2002

Program-wide changes

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

Program-wide changes

?? We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this plan

?? We changed speech therapy benefits by removing the requirements that services must be required to restore functional speech. (Section 5(a)

?? We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a)

?? We now cover certain intestinal transplants. (Section 5(b)

?? Your share of the non-Postal premium will increase by 17.2% for Self Only or 14.2% for Self and Family.

?? Medical Supplies are now covered at 80%.

?? Copays for 60 and 90-day supplies of selected maintenance drugs are now two times and three times the 30-day supply copay.

?? The out-of-pocket maximum has increased to $7,000 for one family member and $18,000 for two or more family members.

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 (812) 426-6600, (800) 521-0265**,** or TDD/TTY (812) 426-9286.

Where you get covered care

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

? **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. You are asked to select a Primary Care Physician (PCP) from our list of participating Family Practice, Internal Medicine, or Pediatric physicians. If you also enroll family members in the Plan, you may select a different PCP for each family member. Most medical care is provided or directed by your PCP. When your PCP determines that you require specialty care, you will be referred to a participating specialist.
You may see your participating OB/GYN physician without a referral for your annual routine exam.

We list participating Plan providers in the provider directory, which we update periodically. This list is also on our website at www.welbornhealthplans.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. This list is also on our website at www.welbornhealthplans.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 (PCP). This decision is important since your PCP provides or arranges for most of your health care. If you are already an established patient of a PCP listed in the provider directory, you may select him or her as your PCP. For assistance in selecting a PCP, call us at (812) 426-6600, (800) 521-0265**,** or TDD/TTY (812) 426-9286.

?**Primary care**

Your Primary Care Physician (PCP) can be a family practitioner, internist or pediatrician. Your PCP will provide most of your health care, or give you a referral to see a specialist.

All eligible services must be either rendered or referred by your designated PCP with the exception of emergency or urgent care and OB/GYN services for your annual exam.

If you want to change PCPs or if your PCP leaves the Plan, call us. We will help you select a new one. You are allowed to change PCPs up to twice annually. You may request a change between the first (1st) through

the fifteenth (15th) of the month. The new PCP will be assigned on the first day of the following month.

If you see a physician who is not your PCP of record, your claim may be denied.

? **Specialty care**

Your Primary Care Physician (PCP) will refer you to a specialist for needed care. Your PCP must arrange the care and submit a referral to the Plan. A referral, or referred, means a request to the Plan from your PCP for services to be rendered by a contracted participating specialist. However, you may see your participating OBGYN for your annual routine exam without a referral.

Here are other things you should know about specialty care:

?? When you receive a referral, you must return to your PCP after the consultation unless he authorizes additional visits. All follow-up care must be provided or authorized by your PCP. If you schedule an appointment with a specialist directly, without obtaining a referral from your PCP, the specialist may ask you to sign a waiver stating you may be financially responsible for the charges incurred.

? If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your PCP will work with your specialist to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your PCP will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

? If you are seeing a specialist when you enroll in our Plan, talk to your PCP. Your PCP 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 PCP, who will arrange for you to see another Plan 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 (PCP) 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 or in a skilled nursing facility when your enrollment in our Plan begins, call our member service department immediately at (812) 426-6600, (800) 521-0265**,** or TDD/TTY (812) 426-9286. If you are new to the FEHB Program, we will arrange for you to receive care.

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

?? You are discharged, not merely moved to an alternative care center; or

?? The day your benefits from your former plan run out; or

?? The 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

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

Services requiring our Prior Approval

Your Primary Care Physician (PCP) must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and follows generally accepted medical practice. Your physician must obtain prior Plan approval for the following services, including but not limited to:

?? Out of network specialists
?? Outpatient Surgical Procedures performed in Ambulatory or Day Surgery Centers with the following *exceptions*:
- Breast Biopsy
- T&A
- Colonoscopy
- Yag Laser
- BTT
- Gastroscopy (EGD)
- Chemotherapy

- Radiation Therapy

?? Sleep Studies
?? Radiology Imaging Studies
- MRI/MRA/CAT Scans
- Cardiac Ultrasounds including Doppler studies
- Bone Densitometry (DEXA)
- PET Scans/SPECT Scans

?? Elective Inpatient Admissions
?? Mental Health/Chemical Dependency Intensive Outpatient Services (After patient has been evaluated)
?? Home Health
?? Hospice
?? Infertility
?? IV Therapy/Infusion Therapy
?? Physical Therapy/Occupational Therapy/Speech Therapy
?? Cardiac and Pulmonary Rehabilitation
?? Durable Medical Equipment dispensed outside the Physician Office with the exception of Glucometers
?? Pain Management
?? Dialysis
?? Transfers by Ambulance
?? Selected Drugs
?? Finally Beat Smoking! Program Prescriptions
?? Tertiary Care (IU)
?? Finally Lose Weight! Program – Refer caller to (812) 426-9730

An Authorization must be obtained in order to receive payment for services.

These items may change from time to time, and we will notify physicians of these changes

Your Primary Care Physician (PCP) (or referred specialist) obtains Plan approval for you before services are scheduled. You should contact your PCP (or referred specialist) to confirm approval, or call our Member Services Department at (812) 426-6600, (800) 521-0265, or TDD/TTY (812) 426-9286.

If you obtain services yourself, without direction from your PCP or referred specialist, or without Plan approval, you will be responsible for the full cost of such services.

Section 4. Your costs for covered services

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

? **Copayments**

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

Example: When you see your Primary Care Physician (PCP) you pay a copayment of $10 per office visit.

?**Deductible**

We do not have a deductible.

?**Coinsurance**

Coinsurance is the percentage of our negotiated fee 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 durable medical equipment and medical supplies.

Your catastrophic protection out-of-pocket maximum

After you pay $7,000 in copayments or coinsurance for one family member, or $18,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments for your prescription drugs do not count toward these limits and you must continue to make payments.

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 6 for how our benefits changed this year and page 59 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. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at (812) 426-6600, (800) 521-0265**,** or TDD/TTY (812) 426-9286.

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.

?? YOUR PHYSICIAN MUST GET PLAN APPROVAL IN ADVANCE OF SOME MEDICAL SERVICES AND SUPPLIES. Please refer to the information shown in Section 3 to be sure which services require prior approval. Items requiring prior approval may change from time to time and we will notify physicians of these changes.

?? 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; ?? Office medical consultations; and ?? Second surgical opinion.	$25 per visit Nothing Nothing $10 per office visit $10 per office visit (referral required)
At home	$10 per 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 (requires prior Plan approval); ?? Ultrasound; and ?? Electrocardiogram and EEG.	Nothing (Note: $10 office visit copay applies when these services are received in conjunction with an office visit.)
Not covered: ?? *Genetic testing for carrier status* ?? *X-rays and lab tests if they are for adoption, custody, school, work, insurance licenses, legal purposes, or travel and lodging*	*All charges*
Preventive care, adult	
Routine screenings, such as: ?? Total Blood Cholesterol – once every three years ?? Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening– every five years starting at age 50 ?? Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	Nothing (Note: $10 office visit copay applies when these services are received in conjunction with an office visit.)
Routine pap test	Nothing (Note: $10 office visit copay applies when these services are received in conjunction with an office visit.)

Preventive care, adult - *Continued on next page*

Preventive care, adult *(continued)*	**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 through 64, one every calendar year; and ?? At age 65 and older, one every two consecutive calendar years	Nothing (Note: $10 office visit copay applies when these services are received in conjunction with an office visit.)
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 (Note: $10 office visit copay applies when these services are received in conjunction with an office visit.)
Preventive care, children	
?? Childhood immunizations recommended by the American Academy of Pediatrics	Nothing (Note: $10 office visit copay applies when these services are received in conjunction with an office visit.)
?? Well-child care charges for routine examinations, immunizations and care up to age 22) ?? Examinations, such as: - Eye exams through age 17 to determine the need for vision correction performed by the child's Primary Care Physician (PCP). - Ear exams through age 17 to determine the need for hearing correction performed by the child's PCP. - Examinations done on the day of immunizations (up to age 22)	$10 per office visit
Not covered: Physical exams and services required for obtaining or continuing employment or insurance, attending schools or camp, legal purposes, licenses, or travel.	*All charges.*

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 precertify your normal delivery; see page 9 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	
A broad range of voluntary family planning services, limited to: ?? Voluntary sterilization ?? Surgically implanted contraceptives (such as Norplant) ?? Injectable contraceptive drugs (such as Depo-Provera) ?? Intrauterine devices (IUDs) ?? Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$10 per office visit
Not covered: ?? *reversal of voluntary surgical sterilization;* ?? *genetic counseling and testing; and* ?? *voluntary abortion except when the life of the mother would be endangered if the fetus were carried to term or when pregnancy is the result of an act of rape or incest.*	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: ?? Artificial insemination: - intrauterine insemination (IUI) ?? Plan approved Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. Sexual dysfunction drugs have dispensing limitations and require documentation of medical necessity from the prescribing physician.	50% per visit or prescription
Not covered: ?? *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete GIFT and zygote ZIFT* - *Zygote transfer* - *intravaginal insemination (IVI)* - *intracervical insemination (ICI);* ?? *Services and supplies related to excluded ART procedures* ?? *Cost of donor sperm* ?? *Cost of donor egg* ?? *Infertility drugs that are not Plan-approved*	*All charges*
Allergy care	
Testing and treatment	$10 per office visit
Allergy injection	$5 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) Note: Growth hormone is covered under the prescription drug benefit. Note: We will only cover GHT when we preauthorize the treatment. Your physician must submit information that establishes GHT as medically necessary.	Nothing
Physical & Occupational Therapies (requires prior Plan Approval)	
?? 20 visits per therapy per condition, if significant improvement can be expected within two (2) months, for the services of each of the following licensed therapists: - physical therapists and - occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. ?? Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living (ADL). ?? Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction.	$10 per office visit $10 per outpatient visit Nothing per visit during covered inpatient hospital admission
Not covered: ?? *community reentry programs;* ?? *developmental stimulation programs;* ?? *long-term rehabilitative therapy;* ?? *exercise programs;* ?? *rehabilitation therapy except when the physician expects a notable improvement in a member's condition;* ?? *vocational rehabilitation.*	*All charges.*

Speech Therapy (requires prior approval)	You pay
?? 20 visits per condition, for the services of a licensed speech therapist.	$10 per office visit $10 per outpatient visit Nothing per visit during covered inpatient admission
Hearing services (testing, treatment, and supplies)	
?? Screening exams to determine the need for hearing correction.	$10 per office visit
Not covered: ?? *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
?? Diagnosis and treatment of diseases of the eye.	$10 per office visit
?? One pair of eyeglasses or contact lenses following cataract surgery. Note: See preventive care, children, for eye exams for children.	All charges exceeding maximum Plan allowance below: Frames $91.00 Single Vision Lens $55.00 pair/ $27.50 lens Bifocal Lens $89.00 pair/ $44.50 lens Trifocal Lens $120.00 pair/ $60.00 lens
Not covered: ?? *Refractions;* ?? *Eyeglasses (other than following cataract surgery) or contact lenses and, examinations for them;* ?? *Eye exercises and orthoptics; and* ?? *Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as: nearsightedness (myopia), farsightedness (hyperopia), and blurring (astigmatism). This includes Radial Keratotomy.*	*All charges.*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$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.* ?? *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery.*	*All charges.*
Orthopedic and prosthetic devices	
?? Artificial limbs and eyes; stump hose; ?? Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy; ?? Corrective and orthopedic devices (such as leg braces); ?? Foot orthotics; ?? Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device; ?? Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	20% Coinsurance
Not covered: ?? *orthopedic and corrective shoes;* ?? *arch supports;* ?? *heel pads and heel cup;* ?? *lumbosacral supports;* ?? *corsets, trusses, elastic stockings, support hose, and other supportive devices;* ?? *replacement of prosthetic devices except for growing children under the age of 18; and* ?? *Myoelectric prosthetic devices;*	*All charges.*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. We follow medical criteria for coverage of DME items. DME items require prior Plan approval. Under this benefit, we also cover: ?? durable medical equipment for home use (such as hospital beds, wheelchairs); ?? crutches; ?? walkers; ?? blood glucose monitors; ?? insulin pumps, and ?? replacement DME for growing children under age 18. Note: Call us at (812) 426-6600, (800) 521-0265**,** or TDD/TTY (812) 426-9286 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% Coinsurance
Not covered: ?? *Accessories, controls, or related appliances that relate to or modify DME, supplies, structure and vehicles;* ?? *DME not needed for the activities of daily living (ADL);* ?? *Duplication or replacement DME;* ?? *Maintainance or repair of DME;* ?? *Batteries;* ?? *Rental costs that are more than the cost of buying DME;* ?? *Lift chairs;* ?? *Motorized wheelchairs;* ?? *Orthopedic shoes; and* ?? *Sphygmomanometers, unless they are used for home dialysis.*	*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.), licensed clinical social worker (L.C.S.W.) or home health aide. Note: Home health care requires prior Plan approval. ?? Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: ?? *nursing care requested by, or for the convenience of, the patient or the patient's family;* ?? *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.*	*All charges.*

Chiropractic	You Pay
Not Covered	*All Charges*
Alternative treatments	
Acupuncture – with a referral from your Primary Care Physician (PCP) is covered for postoperative pain from dental surgery, low back pain, tennis elbow, arthritis, migraines, nausea and vomiting from chemotherapy and anesthesia, and menstrual cramps. Services must be performed by a doctor of medicine or osteopathy.	$20 per office visit
Not covered: ?? *naturopathic services*; ?? *hypnotherapy*; and ?? *biofeedback.*	*All charges.*
Educational classes and programs	
Coverage is limited to: ?? Diabetes self-management ?? Dietician visits to teach about hyperlipidemia or diabetes	Nothing

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

IMPORTANT

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

?? Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

?? Plan physicians must provide or arrange your care.

?? Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

?? The 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 (i.e. hospital, surgical center, etc.)

?? YOUR PHYSICIAN MUST GET PLAN APPROVAL IN ADVANCE OF SOME SURGICAL PROCEDURES. Please refer to the information shown in Section 3 to be sure which services require Plan approval. Items requiring Plan approval may change from time to time and we will notify physicians of these changes.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: ?? Operative procedures ?? Treatment of fractures, including casting ?? Normal pre- and post-operative care by the surgeon ?? Correction of amblyopia and strabismus ?? Endoscopy procedures ?? Biopsy procedures ?? Removal of tumors and cysts ?? Correction of congenital anomalies (see reconstructive surgery) ?? Surgical treatment of morbid obesity -- a condition in which an individual 1) weighs at least two (2) times the ideal weight for frame, age, height, and gender as specified in the 1983 metropolitan Life Insurance tables; 2) has a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions; or 3) a body mass index of at least forty (40) kilograms per meter squared without comorbidity ?? Insertion of internal prostethic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information.	$10 per office visit, nothing for hospital visits
?? Removal of selected benign lesions (lipomas, sebaceous cysts, seborrheic keratoses, and skin tags	50% of charges
?? Voluntary sterilization ?? Treatment of burns	$10 per office visit, nothing per hospital visit

Surgical procedures - *Continued on next page*

Surgical procedures *(Continued)*	**You pay**
Not covered: ?? *Reversal of voluntary sterilization* ?? *Routine treatment of conditions of the foot; see Foot care.* ?? *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.* ?? *Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and blurring (astigmatism).*	*All charges*
Reconstructive surgery	
?? 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.	$10 per office visit, nothing for hospital visit
?? 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.	See above.
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 non-dental surgical and hospitalization procedures for: ?? 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 office visit, nothing per hospital visit
Not covered: ?? *Oral implants and transplants* ?? *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* ?? *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.*	*All charges*
Organ/tissue transplants	
Transplants are covered when approved by the Medical Director. Limited to: ?? Cornea; ?? Heart; ?? Heart/lung; ?? Kidney; ?? Kidney/Pancreas; ?? Liver; ?? Lung: Single –Double; ?? Allogeneic (donor) bone marrow transplants; and ?? 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. ?? Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. Limited to reasonable, established protocols.	Nothing

Organ/tissue transplants - *Continued on next page*

Organ/tissue transplants (Continued)	You Pay
We have a designated transplant network. When transplants are approved in advance as meeting Plan criteria, you will be directed to a facility in this network. 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;* ?? *Animal to human transplants; and* ?? *Transplants not listed as covered.*	*All charges*
Anesthesia	
Professional services provided in – ?? Hospital (inpatient)	Nothing
Professional services provided in – ?? Hospital outpatient department; ?? Skilled nursing facility; ?? Ambulatory surgical center; and ?? Office	Nothing Nothing Nothing $10 per visit

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

IMPORTANT

Here are some important things to remember about these benefits:

?? Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

?? Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.

?? Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

?? The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).

?? YOUR PHYSICIAN MUST GET PLAN APPROVAL IN ADVANCE OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require prior approval.

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. Private rooms are covered only when they are Medically Necessary. This must be in agreement with the written Hospital rules for isolation. (A Physician order does not mean a Member will be Covered for a private room). A Plan Member who otherwise has a private room must pay the difference in cost between a private and semi -private room.	Nothing

Inpatient hospital - *Continued on next page*

Inpatient hospital *(Continued)*	**You pay**
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; and ?? Anesthetics, including nurse anesthetist services. Limited Benefits: Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease. The need for anesthesia, by itself, is not such a condition.	Nothing
Not covered: ?? *Custodial care, rest cures domiciliary, or convalescent care;* ?? *Non-covered facilities, such as nursing home, schools;* ?? *Personal comfort items, such as telephone, television, barber services, guest meals and beds;* ?? *Private nursing care; and* ?? *Take home medications.*	*All charges*
Outpatient hospital or ambulatory surgical center	
Your physician must precertify services performed in an ambulatory surgery center: ?? 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; and ?? Anesthetics and anesthesia service. Limited Benefits: Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease. The need for anesthesia, by itself, is not such a condition	Nothing
Not Covered: ?? *Directed blood donation service for anyone other than yourself*	*All charges*

Extended care benefits/skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): Maximum benefit per condition is 100 days. Your physician must obtain Plan approval in advance of skilled nursing facility stays.	Nothing
Not covered: ?? *Intermediate care* ?? *Custodial care*	*All charges*
Hospice care	
Home or 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	
Non-Emergency ambulance service is covered when medically appropriate and member could not be safely transported in any other way: (Your physician must obtain Plan approval of non-emergency ambulance service) ?? Ground Transportation ?? Air/Water Transportation	 $50 per transport $250 per transport
Not Covered: ?? *Transportation to and from a doctor's office in any way is excluded.*	*All Charges*

Section 5 (d). Emergency services/accidents

IMPORTANT

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

?? Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.

?? Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area:

If you are in an emergency situation, please call your Primary Care Physician (PCP) , using the 24-hour PCP phone number on your Plan ID Card. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g. the 911-telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. Your 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 timely notified.

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

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability, or significant jeopardy to your condition. Any follow-up care recommended by non-Plan providers must be approved in advance by the Plan or provided by Plan providers.

Emergencies outside our 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. Any follow-up care recommended by non-Plan providers must be approved in advance by the Plan or provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	
?? Emergency care at a doctor's office; ?? Emergency care at an urgent care center; and ?? Emergency care as an outpatient or inpatient at a hospital, including doctors' services.	$10 Copay $25 Copay $50 Copay* *waived if admitted
Not covered: Elective care or non-emergency care provided in an emergency setting.	*All charges.*
Emergency outside our service area	
?? Emergency care at a doctor's office; ?? Emergency care at an urgent care center; and ?? Emergency care as an outpatient or inpatient at a hospital, including doctors' services.	$10 Copay $25 Copay $50 Copay* *waived if admitted
Not covered: ?? *Elective care or non-emergency care provided in an emergency setting;* ?? *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area; and* ?? *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges.*
Ambulance	
Emergency ambulance service when medically appropriate for: ?? Ground Transportation ?? Air/Water Transportation See 5(c) for non-emergency service.	 $50 per transport $250 per transport
Not covered: Non-medically necessary ambulance transportation.	*All charges.*

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

IMPORTANT

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

? **YOU MUST GET PLAN APPROVAL IN ADVANCE OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
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
?? Diagnostic tests - Psychological tests - Lab & X-ray	 $10 copay per visit 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

Mental health and substance abuse benefits - *Continued on next page*

Mental health and substance abuse benefits *(Continued)*	**You pay**
Not covered: ?? *Services we have not approved in advance;* ?? *Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate; and* ?? *Any services for similar benefits that were excluded or limited for other illnesses and conditions.* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Prior Plan Approval

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

Your mental health/substance abuse professional provider must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow up care. Before giving approval, we consider if the services are medically necessary, and follow generally accepted medical practice guidelines.

Limitation

We may limit your benefits if you do not obtain a 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.

?? Certain drugs require Plan approval before dispensing in order to be covered. Your participating physician will make arrangements for prior approval. Call the Plan at (812) 426-6600, (800) 521-0265**,** or TDD/TTY (812) 426-9286 if you have questions about this process. The Pharmacy & Therapeutics Committee defines the drugs that require advance Plan approval before dispensing and the criteria under which they will be covered. These drugs, and the criteria for coverage, are subject to change based on the Pharmacy & Therapeutics Committee's drug literature reviews. Drugs requiring prior Plan approval are excluded from coverage if Plan approval is not obtained.

?? As an added convenience, you may refill (first prescription must be filled at the local retail pharmacy) covered selected maintenance drugs prescribed to treat chronic conditions like arthritis, high blood pressure, heart conditions and diabetes through our Mail Service Program. Birth control pills and estrogen may also be refilled.

?? Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

?? **Who can write your prescription.** A plan physician must write the prescription except when approved in advance or for covered emergencies. For Out-of-Area Urgent care, a physician must write the prescription. Refills must be obtained in the service area.

?? **Where you can obtain them.** You may fill the prescription at a participating network pharmacy, or by mail. To receive full benefits, you must present your ID Card at a participating Pharmacy each time a prescription needs to be filled. Failure to present your ID Card may result in a reduction of benefits. Prescriptions filled at non-participating pharmacies are not covered. Refer to the Provider Directory for a wide list of local participating pharmacies. You also have access to over 25,000 national chain and independent pharmacies when you travel. Call MedImpact Customer Service at (800) 788-2949 or our Member Service Department at (812) 426-6600, (800) 521-0265**,** or TDD/TTY (812) 426-9286 ahead of time to locate a pharmacy nearest your destination.

Continued on next page

?? **We have an open formulary.** 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" for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic, plus the name brand copayment. 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 Welborn Health Plans' Selected Pharmaceutical List (SPL). The SPL is a list of preferred medications rigorously reviewed and selected for their safety, quality, and effectiveness by our Pharmacy & Therapeutics Committee. If a brand drug is not on the Welborn Health Plans SPL, it is referred to as a non-preferred drug. Non-preferred brand drugs are covered; however, a higher copay is required than for preferred brand drugs. The SPL will be amended from time to time at the direction of the Pharmacy & Therapeutics Committee. To request prescription drug information, please call Welborn Health Plans' Member Services Department at **(812) 426-6600, (800) 521-0265, or TDD/TTY (812) 426-9286.**

?? **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply or 100 unit supply, whichever is less, or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). In lieu of name brand drugs, generic drugs will be dispensed when substitution is permissible. When generic substitution is permissible (i.e. a generic drug is available and the prescribing doctor does not require the use of a brand name drug), but you request the brand name drug, you pay the price difference between the generic and name brand drug as well as the name brand drug copay per prescription unit or refill. If there is no generic equivalent available, member will still have to pay the brand name copay. Note: Remember that certain drugs may require prior Plan approval. As an added convenience, you may refill (first prescription must be filled at the local retail pharmacy) selected covered maintenance prescription drugs prescribed to treat chronic conditions like arthritis, high blood pressure, heart conditions and diabetes through our mail service program. Please contact our Member Services Department at (812) 426-6600, (800) 521-0265**,** or TDD/TTY (812) 426-9286 for information and a mail order form.

?? **Why use generic drugs?** Generic drugs offer a safe and economical way to meet your prescription drug needs. The generic name of a drug is it's chemical name; the brand name is the name under which a manufacturer advertises and sells a drug. The US Food and Drug Administration (FDA) sets quality standards to ensure that generic drugs meet the same standards for effectiveness, strength, purity and safety. Generic drugs cost you and your plan less money than brand name drugs.

?? **When you have to file a claim.** If you are not able to locate a participating network pharmacy and need an emergency prescription (not a refill), you may pay for the prescription and submit the pharmacy receipt to Welborn Health Plans, 421 Chestnut Street, Evansville IN 47713, ATTN: Claims Department. You will be reimbursed for covered prescriptions filled for eligible emergencies or out-of-area urgent conditions, less the applicable copayment.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: ?? Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as not covered; ?? Insulin –one copay per vial; ?? Disposable needles and syringes for the administration of covered medications; ?? Drugs for sexual dysfunction (requires Plan approval before dispensing); ?? Oral Contraceptive drugs, including Depo Provera and contraceptive devices; and ?? Growth hormone therapy (GHT) Note: – Growth hormone therapy is covered under the prescription drug benefit. We will only cover GHT when we approve the treatment in advance. Your physician must obtain approval from the Plan to establish that GHT is medically necessary. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. ?? Lancets and strips Please Note: Lancets and strips are covered as medical supplies at 80% and you pick them up at the pharmacy. Limited Drugs: ?? Migraine therapy drugs ?? Sexual Dysfunction Drugs ?? Stimulants (e.g. Provigil, Concerta) ?? Sustained release pain medications (e.g. Oxycontin, MS, Contin)	<u>Drugs Up to a 30 Day Supply or 100 unit supply, whichever is less, or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin):</u> $5 Copay – Generic $15 Copay – Brand on formulary $25 Copay – Brand non-formulary *Note: Your copay will not exceed the cost of the drug. **For refills of Selected Maintenance Drugs:** <u>60 Day Supply:</u> $10 Copay – Generic $30 Copay – Brand on formulary $50 Copay – Brand non-formulary <u>90 Day Supply</u> $15 Copay – Generic $45 Copay – Brand on formulary $75 Copay – Brand non-formulary Notes: (1) If there is no generic equivalent available, you will still have to pay the brand name copay. (2) Your copay will not exceed the cost of the drug.
?? Plan-approved fertility drugs (requires Plan approval before dispensing.)	<u>Approved Fertility Drugs</u> 50% Coinsurance

Covered medications and supplies - Continued on next page

Covered medications and supplies *(continued)*	**You pay**
Not covered: ?? *Dental drugs prescribed by a dentist or oral surgeon;* ?? *Drugs and supplies for cosmetic purposes;* ?? *Drugs to enhance athletic performance;* ?? *Drugs for which there is a nonprescription equivalent available;* ?? *Implanted time-release medications other than Norplant;* ?? *Medical supplies such as dressings and antiseptics;* ?? *Nonprescription medicines;* ?? *Prescriptions written by non-participating providers or filled by non-participating pharmacies (except when approved in advance or for covered emergencies or out of area urgent care);* ?? *Smoking cessation medications;* ?? *Take home medications from a hospital or other facility;* ?? *Weight-loss medications; and* ?? *Vitamins, nutrients, formulas and food supplements even if a physician prescribes or administers them.*	*All Charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. ?? We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. ?? Alternative benefits are subject to our ongoing review. ?? By approving an alternative benefit, we cannot guarantee you will get it in the future. ?? The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. ?? Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	For those hearing impaired, please call our TDD/TTY number at (812) 426-9286.
Centers of excellence for transplants/heart surgery/etc	Welborn Health Plans uses Centers of excellence for covered transplants. These specific institutions are selected on the basis of expertise and outcomes statistics. Precertification is required.

Section 5 (h). Dental benefits

IMPORTANT

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

?? Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

?? Plan dentists must provide or arrange your care.

?? 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. You or your physician must notify us of the injury so we may pre-certify covered restorative dental services and supplies. Repairs must be approved in advance and must be done within 12 months after the date of the injury.	Nothing
Dental benefits	
We have no other dental benefits.	*All charges*

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Benefit Description	You pay
Finally BEAT Smoking! (Referral required from your Welborn Health Plans Primary Care Physician (PCP). Plan approval is required before prescriptions are dispensed). Covered Services: ?? Acupuncture; ?? Hypnosis/Individual Therapy; ?? Inhaler/Nose Spray; ?? Patches (prescription required); ?? Zyban; ?? Smoking Cessation Program; ?? Nicorette Gum; and ?? Support Group.	50% of first $500, then full charges.
Finally Lose Weight, The Healthy Way This is a weight loss class incorporated in a special Weight Watchers? version. The registration fee is waived.	Weekly fee paid to Weight Watchers?
Medicare Prepaid Plan Enrollment This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 44, certain annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on changing to a Medicare prepaid plan. Contact us at (812) 426-6600, (800) 521-0265 or TDD/TTY (812) 426-9286 for more information on changing to a Medicare prepaid plan and the cost of that enrollment. If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call (812) 426-6600, (800) 521-0265 or TDD/TTY (812) 426-9286 for more information on the benefits available under the Medicare HMO.	Please call (812) 426-6600, (800) 521-0265 or TDD/TTY (812) 426-9286 for rate information

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 treal your illness, disease, injury or condition.**

?? Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefit

?? 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; or

?? 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 obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

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

Medical, Hospital and Drug Benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at (812) 426-6600, (800) 521-0265, or TDD/TTY (812) 426-9286.

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 the physician or facility that provided the service or supply;

?? Dates you received the services or supplies;

?? Diagnosis;

?? Type of each service or supply;

?? The charge for each service or supply;

?? A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN); and

?? Receipts, if you paid for your services.

Submit your claims to: **Welborn HMO**
Claims Department
421 Chestnut Street
Evansville, IN 47713

Do I have to submit claims?

You normally will not have to submit claims to us unless you receive emergency services from a provider who does not contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service, 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: Welborn HMO, 421 Chestnut Street, Evansville IN 47713; 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 medical 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, 1900 E. Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

?? A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;

?? Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;

?? Copies of all letters you sent to us about the claim;

?? Copies of all letters we sent to you about the claim; and

?? Your daytime phone number and the best time to call.

Note: If you want OPM to review 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 include a copy of your specific written consent with the review request.

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

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

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, or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (812) 426-6600, (800) 521-0265**,** or TDD/TTY (812) 426-9286 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 medical expenses without regard to fault. This is called "double coverage."

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

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

? People 65 years of age and older.

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

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

Medicare has two parts:

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

? Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

? The Original Medicare Plan (Part A or Part B)

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

.

When you are enrolled in Original Medicare along with this plan, you still need to follow the rules in this brochure for us to cover your care.

Your care must continue to be authorized by your Plan PCP, or precertified as required.

We will not waive any of our copayments, coinsurance, and deductibles.

(Primary payer chart begins on next page.)

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

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

Please note if your Plan physician does not participate in Medicare, you may have to file a claim with Medicare.

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

?? When we are the primary payer, we process the claim first.

?? When Original Medicare is the primary payer, Medicare precesses 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 (812) 426-6600, (800) 521-0265 or TDD/TTY *(812) 426-9286.*

? **We do not waive any costs when you have Medicare.**

? **Medicare managed care plan**

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

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

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance, for your FEHB coverage.

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

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare managed care plan. 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 service area.

If you do not enroll in Medicare Part A or Part B

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

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 illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or

? OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will determine our allowance. We will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. 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

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

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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.

Coinsurance

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

Copayment

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

Covered services

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

Custodial care

This type of care is mostly given to maintain rather than improve your health status or to control or change the patient's environment. For example, this type of care could be given by a non-licensed person to meet personal or domestic needs, convalescent care, rest cures, and nursing homes.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. This plan does not have a deductible.

Experimental or investigational Services

Experimental or investigational means any drug, device, or service that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device, or service is furnished.

Medical necessity

Medical necessity means medical services, equipment or supplies that are determined to be:

i. In accordance with the symptoms, diagnosis, and treating of a member's condition, disease, illness, or injury;
ii. Suited to the standards of good medical practice;
iii. Not only for the convenience of the member or the member's provider; and
iv. The most fitting place, supply, or level of service that can be safely given to the member.

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: Welborn Health Plans pays it's Providers using various payment methods, including capitation, per diem, and discounted fee-for-service arrangements. Capitation means paying a fixed dollar amount per month for each Member assigned to the Provider. Per Diem means paying a fixed dollar amount per day for all services rendered. Discounted fee-for-service means paying the Provider's usual, customary and regular fee discounted by an agreed-to percentage. Participating Providers accept the plan allowance as payment in full.

Us/We

Us and we refer to Welborn HMO.

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

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.

?Temporary Continuation of Coverage

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for*

Temporary Continuation of Coverage and Former Spouse Enrollees, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll

? **Converting to indivual coverage**

You may convert to a non-FEHB policy if:

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

? You decided not to receive coverage under TCC or the spouse equity law; or

? You are not eligible for coverage under TCC or the spouse equity law.

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

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27 Temporary Continuation o f Coverage (TCC) under the FEHB Program. See also he FEHB web site (www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked question. HIPPA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPPA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

?? Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!

?? How are YOU planning to pay for the future custodial or chronic care you may need?

?? You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

?? It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.

?? LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or, will I?

?? Welcome to the club!

?? 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.

?? We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

?? Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8-hour shifts a week can exceed $20,000 a year. And that's before inflation!

?? Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

?? Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.

?? Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.

?? Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

?? Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
?? Retirees will receive information at home.

How can I find out more about the program NOW?

?? Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

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

Summary of benefits for Welborn HMO- 2002

?? **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	$10 per office visit	13
Services provided by a hospital:		
?? Inpatient.....	Nothing	27
?? Outpatient.....	Nothing	28
Emergency benefits:		
?? In-area	$50 per emergency room visit	31
?? Out-of-area	$50 per emergency room visit	31
Mental health and substance abuse treatment.....	Regular cost sharing	32
Prescription drugs.....	Drugs up to a 30-day supply	36
?? Drugs up to a 30-day supply or 100 unit supply, whichever is less, or one commercially prepared unit.	$5 copay Generic $15 copay Brand on formulary $25 copay Brand non-formulary (60 and 90-day supplies available at a higher copay for selected maintenance drugs)	
Dental Care	Nothing for accidental injury benefit	39
Vision Care	All charges exceeding maximum Plan allowance for one pair of eyeglasses or contact lenses following cataract surgery .	
Special features: Flexible benefit option, Services for the deaf and hearing impaired, Centers of Excellence for transplants		38

Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $7,000/Self Only or $18,000 Family enrollment per year Some costs do not count toward this protection	11

2002 Rate Information for Welborn Health Plans

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, 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 who are not carrer postal employees.. Refer to the applicable FEHB Guide.

Type of Enrollment	Code	*Non-Postal Premium* Biweekly Gov't Share	Biweekly Your Share	Monthly Gov't Share	Monthly Your Share	*Postal Premium* Biweekly USPS Share	Biweekly Your Share
Self Only	**H31**	**$ 97.86**	**$ 36.50**	**$212.03**	**$ 79.08**	**$115.52**	**$ 18.84**
Self & Family	**H32**	**$223.41**	**$123.94**	**$484.06**	**$268.53**	**$263.75**	**$ 83.60**