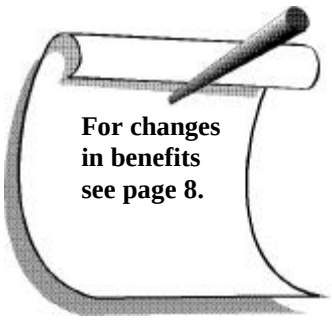
Western Health Advantage

http://www.westernhealth.com

2002

A Health Maintenance Organization



Serving: Portions of Northern California

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

This Plan has " New Plan" accreditation from the NCQA. See the 2002 Guide for more information on NCQA

Enrollment codes for this Plan:

5Z1 Self Only
5Z2 Self and Family

Authorized for distribution by the:

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

Federal Employees
Health Benefits Program

RI 73-780

Table of Contents

Introduction

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

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

If you are enrolled in this Plan you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 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 changes are summarized on page 8. 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 Western Health Advantage.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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

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 1-888-563-2250 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, or coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

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

Who provides my health care

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

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

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

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.

- Western Health Advantage is a full service, not-for-profit health care plan operating in Sacramento, Yolo, and portions of Placer, Solano, and El Dorado Counties.
- Western Health Advantage was created by local health care providers in 1997 who believe health care can be delivered in a managed care environment without sacrificing service and quality.

- Western Health Advantage has been granted "New Health Plan" Accreditation effective December 1, 1999 by NCQA.

If you want more information about us, call 916/563-2250 or toll free 1-888/563-2250, or write to:

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

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

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: all of Sacramento and Yolo Counties, and portions of the following counties: Placer, El Dorado and Solano (zip codes shown below).

Placer County zip codes:

95602, 95603, 95604, 95631(partial), 95648, 95650, 95658, 95661, 95663, 95677, 95678, 95681, 95703, 95713, 95722, 95736, 95746, 95747, 95765

El Dorado County zip codes:

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

Solano County zip codes:

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

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

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

Section 2. How we change for 2002

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

- Your share of the non-Postal premium will increase by 21.3% for Self Only or 21.3% for Self and Family.
- We now show coverage for certain intestinal transplants. (Section 5(b))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech, and we now provide coverage for speech therapy at 14 visits per condition subject to a $10 copay per visit. (Section 5(a))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We have contracted with Magellan Behavior Inc. to administer our Mental Health and Substance Abuse benefit. (Section 5(e))
- We have changed our Drug Pharmacy Manager to Merck-Medco Inc. (Section 5(f))

Section 3. How you get care

Identification cards

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

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

Where you get covered care

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

· Plan providers

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

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

· Plan facilities

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

What you must do to get covered care

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

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

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

· Primary care

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

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

· **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, women can self-refer to participating OB/GYN doctors whenever they need these services, without a referral, and everyone can self-refer for an annual eye exam to one of the participating eye specialists.

Here are other things you should know about specialty care:

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

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

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

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

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

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

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

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

· **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Member Service Department immediately at 916/563-2250 or

1-888/563-2250. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

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

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

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

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

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

- Infertility services are covered including testing, consultations, examinations, diagnostic surgical services related to hospitalizations or facilities, and drug therapy. Services are covered when obtained with prior authorization.
- Chiropractic care (when traditional therapies have been ineffective), when obtained from participating providers upon referral from primary care physician and with prior authorization.
- Acupuncture, (when traditional therapies have been ineffective), when obtained from participating providers upon referral from primary care physician and with prior authorization.
- Non-emergency medical transport inside or outside the service area, except with prior authorization.
- Medically necessary services as determined by WHA, for the treatment of morbid obesity with a prior authorization.

Section 4. Your costs for covered services

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

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

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

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

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

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

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

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

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

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 58 for a benefits summary.)

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

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility	Nothing
• Office medical consultations ? Second surgical opinion	$10 per office visit
? At home	$10 per office visit

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including – Fecal occult blood test	$10 per office visit, no charge if performed at laboratory only.
– Sigmoidoscopy, screening – every five years starting at age 50	$10 per office visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office visit, no charge if performed at laboratory only.
Routine pap test	$10 per office visit, no charge for test.
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 and over, one every calendar year	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing for immunizations, office visit copay may apply.

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (through age 22) • Examinations, such as: – Eye exams – Ear exams – Examinations done on the day of immunizations	$10 per office visit
? Testing and treatment of Phenylketonuria (PKU), which includes the cost of any special foods or formula over and above a "regular diet"	$10 per office visit
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to preauthorize your normal delivery; see page 29 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*

Family planning	You pay
A broad range of voluntary family planning services, limited to:	
• Voluntary sterilization	$10 per office visit
• Surgically implanted contraceptives (such as Norplant)	$200 copayment for Norplant and other implanted time-release contraceptives.
? Injectable contraceptive drugs (such as Depo provera)	$10 per office visit.
? Intrauterine devices (IUDs)	$10 per office visit.
? Diaphragms	$10 per office visit.
NOTE : We cover oral contraceptives under the prescription drug benefit.	
Not covered: reversal of voluntary surgical sterilization, genetic counseling.	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as:	50% of the charges
• Artificial insemination:	
- *intravaginal insemination (IVI)*	
- *intracervical insemination (ICI)*	
- *intrauterine insemination (IUI)*	
• Fertility drugs	50% of charges
Services may include one gamete interfallopian transfer ("GIFT") or one in-vitro fertilization (IVF) but only one of these procedures is covered per Lifetime.	50% of charges
Not covered:	
• *Assisted reproductive technology (ART) procedures, such as:*	*All charges.*
• *embryo transfer*	
• *Services and supplies related to excluded ART procedures*	
• *Cost of donor sperm*	
• *Cost of donor egg*	

Allergy care	You pay
Testing and treatment	$10 per office visit
Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	
• 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 26. • 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.	Nothing
Physical and occupational therapies	
For the services of each of the following: – qualified physical therapists; – occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. ? Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions	$10 per office visit $10 per outpatient visit Nothing per visit during covered inpatient admission $10 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*

Speech therapy	You pay
• 14 visits per condition	$10 per office visit
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury	$10 per office visit
• Hearing testing for all ages.	$10 per office visit
Not covered: • *hearing aids, testing and examinations for them, except when necessitated by accidental injury* • *hearing aid batteries.*	*All charges.*
Vision services (testing, treatment, and supplies)	
• Annual eye exam	$10 per office visit
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per office visit
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care, children)	$10 per office visit
• Annual eye refractions	$10 per office visit
Not covered: • *Eyeglasses or contact lenses (except as above) or frames* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery.*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit

Foot care – *continued on next page*

Foot care *(Continued)*	**You pay**
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	20% of charges
• Leg and knee braces; foot orthotics when medically necessary	20% of charges
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy	20% of charges
• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device.	
• Penile Prostheses which are medically necessary secondary to trauma, tumor, or physical disease to the circulatory system or nerve supply and are not of a psychological cause.	50% of charges
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	20% of charges
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics when not medically necessary* • *heel pads and heel cups* • *back braces or other lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen, oxygen equipment and dialysis equipment. Under this benefit, we also cover: • hospital beds; • standard wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps.	20% of charges
Not covered: • *Motorized wheelchairs*	*All charges.*
Home health services	
• *Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.* • *Services include oxygen therapy, intravenous therapy and medications.*	Nothing
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	
Services must be obtained by a referral from your WHA primary care doctor and obtained from a Landmark Healthcare participating plan chiropractor. Up to 20 visits per calendar year are covered with prior authorization. Services include the following: • Examinations • Manipulation • Conjunctive Physiotherapy • X-rays	$15 per office visit

Alternative treatments	You pay
Acupuncture - Services must be obtained by a referral from your WHA primary care doctor and obtained from a Landmark Healthcare participating Acupuncturist. Up to 20 visits per calendar year are covered with prior authorization. Services include the following: • Acupuncture • Electroacupuncture • Moxibustion • Cupping • Acupressure, when acupuncture is not clinically appropriate	$15 per office visit
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges.*
Educational classes and programs	
Coverage is limited to: Smoking Cessation-Nicotine transdermal systems, such as Habitrol or Nicoderm are covered as a "Wellness Benefit". You must obtain a prescription from your primary care physician. One 10-week treatment will be covered per member under any current or future WHA contract.	100% of the cost of the medication, initially. Upon remaining smoke free for 90 days after treatment, as certified by your physician, WHA will reimburse you in full. You must be an active participant in WHA at the time of the reimbursement. Reimbursement should be requested within 60 days of certification.
• Diabetes self-management	$10 per office visit

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Surgical procedures	
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 weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office 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.*	*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.	Nothing
• All stages of breast reconstruction surgery following a mastectomy, such as: – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing 20% of charges
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

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

Organ/tissue transplants *(Continued)*	**You pay**
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

Here are some important things to remember about these benefits:

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

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing

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

Section 5 (d). Emergency services/accidents

IMPORTANT

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

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

IMPORTANT

What is a medical emergency?

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

Emergency Services and Care also pertain to:

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

What to do in case of emergency:

Emergencies within the service area:

When an Emergency situation arises call "911" or go directly to the nearest hospital Emergency Room. If that care is obtained from a non-Participating Provider, we will reimburse the provider for covered medical services received for Emergency situations, less the applicable co-payment.

If you are hospitalized at a non-participating facility because of an Emergency, WHA must be notified within 24 hours unless it was not reasonably possible to notify the Plan within that time. This telephone call is extremely important. If you are unable to make the call, have someone else make it for you, such as a Family Member, friend or hospital staff member. WHA will work with the hospital and Physicians coordinating your care and, if possible, arrange for your transfer back to a participating hospital as well as make appropriate payment provisions.

Follow-up care after an emergency room visit is not considered an Emergency situation. If you receive Emergency treatment from an emergency room physician or non-Participating Physician and you return to the emergency room or physician for follow-up care (for example, removal of stitches or redressing a wound), you will be responsible for the cost.

Call your Primary Care Physician for all follow-up care. If your health problem requires a specialist, he/she will refer you to an appropriate Participating provider as needed.

Emergency services/accidents – *continued on next page*

Emergency services/accidents *(Continued)*

Emergencies outside the service area:

WHA covers you for Urgent Care and Emergency Care services wherever you are in the world. Please note that emergency room visits are not covered for non-Emergency situations. When an Emergency situation arises while you are outside of the Service Area call "911" or go directly to the nearest hospital Emergency Room.
Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you are hospitalized at a non-participating facility because of an Emergency, WHA must be notified within 24 hours unless it was not reasonably possible to notify the Plan within that time. This telephone call is extremely important. If you are unable to make the call, have someone else make it for you, such as a Family Member, friend or hospital staff member. WHA will work with the hospital and Physicians coordinating your care and, if possible, arrange for your transfer back to a participating hospital as well as make appropriate payment provisions.

Follow-up care after an emergency room visit is not considered an Emergency situation. If you receive Emergency treatment from an emergency room physician or non-Participating Physician and you return to the emergency room or physician for follow-up care (for example, removal of stitches or redressing a wound), you will be responsible for the cost.

Call your Primary Care Physician for all follow-up care. If your health problem requires a specialist, he/she will refer you to an appropriate Participating provider as needed.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center	$15 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services.	$50 per visit (copay is waived if admitted to a hospital)
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center	$15 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit (copay is waived if admitted to a hospital)
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges.*

Ambulance	You pay
• Professional ambulance service, including air ambulance, when medically appropriate. See 5(c) for non-emergency service.	Nothing

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 CALL MAGELLAN BEHAVIORAL HEALTH, INC. TO ACCESS SERVICES.** See the instructions after the benefits description below.

IMPORTANT

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

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

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

Preauthorization

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

- You do not need a referral from your primary care physician.
- You **must** call Magellan Behavioral Health Inc. at 1-800/424-1778 to access behavioral health and substance abuse services. Notification is required for services at all levels of care to avoid non-authorization of benefits.
- Inpatient services must be authorized by Magellan prior to admission or within 48 hours of an emergency admission.
- Outpatient services are authorized by calling the Magellan 800 number for a referral and authorization to a Magellan provider.

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.
- Some medications may require prior authorization to ensure the appropriate use of the drug.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy, or by mail if the prescription is for maintenance medications, which are to be taken beyond 60 days. You may contact Merck-Medco Customer Services department at 1-800/903-8664, to request additional "Prescription by Mail" order forms.
- **We use a formulary. The "Three Tier Copay Plan"** means there is not a closed formulary, but three different copays. All generic medications are covered at the lowest copay; brand name medications on the formulary, i.e., Preferred Drug List (PDL) have the middle level copay; and brand name medications not on the formulary, i.e., PDL (non-preferred or non-formulary) have the highest copay. However, in all three categories a number of the drugs may need prior authorization to ensure the appropriate use of the drug. Members may request a copy of the PDL by calling 1-888/563-2250 or view the document on the web page: www.westernhealth.com.

- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. **You pay** a $5 copay per prescription unit or refill for generic drugs or $10 copay per prescription unit or refill for name brand drugs on the formulary, i.e., Preferred Drug List (PDL); and a $20 copay per prescription unit or refill for Non-Preferred (non-formulary) name brand medications per each 30-day supply or 120-unit supply, whichever is less. In no event will the copay exceed the cost of the prescription drug. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and name brand drug as well as the $10 copay per prescription unit or refill. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's formulary policy. Non-formulary drugs will be covered when prescribed by a Plan doctor.
  Covered prescription medications that are to be taken beyond 60 days are considered maintenance medications. Maintenance medications are used in the treatment of chronic conditions like arthritis, high blood pressure, heart conditions, and diabetes. Oral contraceptives are also available through the mail order program. Maintenance medications may be obtained through Merck-Medco mail order service, WHA's pharmacy benefit manager. You can request the order form and brochure for this benefit by contacting Merck-Medco Customer Service Department at 1-800/903-8664 The initial prescription for maintenance medications is dispensed through a participating pharmacy (limited to a 30-day supply). Subsequent refills for a 90-day supply may be obtained through the Mail Order Program. You pay a $10 copay for a 90-day supply of generic medication, a $20 copay for a 90-day supply of brand name medication on the formulary, i.e., Preferred Drug List (PDL); and a $40 copay for a 90-day supply of brand name medication which is Non-Preferred (non-formulary) through the Mail Order Program. In this way, you receive a 90-day supply of medication for only two copays.

Why use generic drugs? Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us—less than a name brand prescription.

When you have to file a claim. If you have to pay for a covered prescription, you may submit your receipt, along with a claim form to PAID Prescriptions, L.L.C., an affiliate of Merck-Medco, and you will be reimbursed for the cost of the medication, less the applicable copay. To obtain claim forms call Merck-Medco Member Services at 1-800/903-8664.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by state or Federal law of the United States, require a physician's prescription for their purchase, except those listed as *Not Covered* • Insulin with a copay charge applied to each vial • Disposable needles and syringes for the administration of covered medications • Glucose test tablets and test tape, Benedict's solution or equivalent, and acetone test tablets are covered up to a 30-day supply per copay • Contraceptive drugs and devices including diaphragms • Inhalers (limited to two per prescription) • Prescription prenatal vitamins or vitamins in conjunction with fluoride	**Retail pharmacy:** $5 copay per 30-day supply for generic drugs $10 copay per 30-day supply for formulary, i.e., preferred name brand drugs $20 copay per 30-day supply for name brand drugs not on the formulary, i.e., Preferred Drug List Mail order pharmacy: $10 copay per 90-day supply for generic drugs $20 copay per 90-day supply for formulary, i.e., preferred name brand drugs $40 copay per 90-day supply for name brand drugs not on the formulary, i.e., Preferred Drug List Note: If there is no generic equivalent available, you will still have to pay the name brand copay
• Drugs for sexual dysfunction. Episodic medications for the treatment of sexual dysfunction are limited to 6 pills per 30-day supply. • Fertility drugs	50% of charges
? Covered medications dispensed by a non-participating pharmacy outside of WHA's Service Area for Urgent Care or Emergency care only. **Maximum 10 day supply.**	Submit your receipt to PAID Prescriptions, L.L.C., an affiliate of Merck-Medco, and you will be reimbursed the full purchase price less the applicable copayment

Covered medications and supplies - *continued on next page*

Covered medications and supplies *(continued)*	**You pay**
• Nicotine transdermal systems, such as Habitrol or Nicoderm are covered as a "Wellness Benefit". You must obtain a prescription from your primary care physician. **One 10-week treatment will be covered per member under any current or future Western Health Advantage contract.**	100% (Upon remaining smoke-free for 90 days as certified by your primary care physician, Western Health Advantage will reimburse you in full. You must be active with Western Health Advantage at the time of reimbursement. Reimbursement should be requested within 60 days of certification)
Not covered: • *Drugs and supplies for cosmetic purposes;* • *Vitamins, nutrients and food supplements that can be purchased without a prescription (except for special food products that are medically necessary for the treatment of PKU) even if a physician prescribes or administers them;* • *Nonprescription medicines.* • *Medical supplies such as dressings and antiseptics* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Drugs to enhance athletic purposes*	*All Charges*

Section 5 (g). Special features

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

Section 5 (h). Dental benefits

IMPORTANT

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

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

IMPORTANT

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

Dental benefits

We have no other dental benefits.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 11.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; 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 fill your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, or coinsurance.

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

Medical and hospital 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 916/563-2250 or 1-888/563-2250.

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

- Covered member's name and ID number;
- Name and address of 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:

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

Prescription drugs

If you have to pay for a covered medication in an urgent/emergent situation, and use a non-participating pharmacy, you will need to submit a Merck-Medco claim form with your receipt. To obtain a claim form call Merck-Medco Customer Services Department at 1-800-903-8664. You will be reimbursed in full less the applicable copay. Submit the claim form and your receipt to:

PAID Prescriptions, L.L.C.
P.O. Box 2277
Lee's Summit, MO 64063-2277

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Western Health Advantage, 1331 Garden Highway, Suite 100, Sacramento, CA 95833-9773; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630

The Disputed Claims Process *(Continued)*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters 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 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 916/563-2250 or 1-888/563-2250 and we will expedite our review; or

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

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

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

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

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

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

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

care must continue to be authorized by your primary care physician. WHA does not duplicate any benefits to which members are entitled under workers' compensation law, employer liability laws, Medicare Part A and B, or TRICARE (CHAMPUS). WHA retains all sums payable under these laws for services provided.

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

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

(Primary payer chart begins on next page.)

The following chart illustrates whether 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 Primary Care Physician does not participate in Medicare, you will 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 processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 916/563-2250.

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

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

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, 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 to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

· If you do not enroll in Medicare Part A or 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 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 cover your care. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

If you have a malpractice claim

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

Covered services

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

Custodial care

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

Experimental or investigational services

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

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

Group health coverage

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

Medical necessity

Means that which WHA determines:

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

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

Plan allowance

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

- your portion of the cost is a percentage of the Plan's discounted contract rate and the contract rate is payment in full.

Us/We

Us and we refer to Western Health Advantage (WHA)

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you 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 (TCC)

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

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

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

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Long Term Care Insurance Is 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 the terms appear.

Summary of benefits for *Western Health Advantage* – 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	Office visit copay: $10 primary care; $10 specialist	15
Services provided by a hospital: • Inpatient..... • Outpatient	 Nothing Nothing	28 29
Emergency benefits: • In-area..... • Out-of-area.....	 $50 per hospital emergency room $50 per hospital emergency room	30 31
Mental health and substance abuse treatment.....	Regular cost sharing	33
Prescription drugs..... Retail pharmacy for up to a 30 day supply per prescription unit or refill Mail order for up to a 90 day supply per prescription unit or refill	**Retail pharmacy**: $5 copay for generic drugs; $10 copay for formulary name brand drugs; and $20 copay for non-formulary name brand drugs **Mail order pharmacy**: $10 copay for generic drugs; $20 copay for formulary name brand drugs; and $40 copay for non-formulary name brand drugs	35
Dental Care …… We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing	39
Vision Care..... Annual eye exams; one pair eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts); eye exam to determine the need for vision correction for children through age 17; and annual eye refractions.	$10 per office visit	20
Special features: Advantage Referral Program		38
Protection against catastrophic costs ..... (Your out-of-pocket maximum)	Nothing after $750/Self Only or $1,500/Self and Family enrollment per year Some costs do not count toward this protection	13

2002 Rate Information for
WESTERN HEALTH ADVANTAGE

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses, 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 career postal employees. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	5Z1	$81.66	$27.22	$176.93	$58.98	$96.63	$12.25
Self and Family	5Z2	$195.98	$65.33	$424.63	$141.54	$231.91	$29.40