Western Health Advantage 1999

A Health Maintenance Organization

Serving:

Portions of Northern California
Enrollment in this Plan is limited; see page 8 for requirements.

Enrollment code:

5Z1 Self only
5Z2 Self and family

Visit the OPM website at http://www.opm.gov/insure
and
This Plan's website at http://www.westernhealth.com

Special Notice:	This Plan is being offered for the first time under the Federal Employees Health Benefits Program during the 1998 Open Season.

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

Western Health Advantage

Western Health Advantage, 1331 Garden Hwy., Ste. 100, Sacramento, CA 95833, has entered into a contract (CS 2840) with the Office of P (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called WHA,

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in thi for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FE the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medic and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did n same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 888-563-2250 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

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

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

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

If you are a new member

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

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

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, a employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 13**. If you are confined in a hospital on the effective date, you notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hosp page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may h the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

General Information *continued*

If you are hospitalized

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

Your responsibility

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

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan. If yo plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's nev effective the first day of the enrollee's first full pay period that begins on or after January 1 (January annuitants).

- Generally, you must be continuously enrolled in the FEHB Program for the last five years before yo continue your enrollment for you and any eligible family members after you retire.

- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumst will also be provided under a family enrollment for a disabled child 22 years of age or older who is i self-support.

- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment cha day of the pay period in which the child was born or became an eligible family member. The enroll responsible for his or her share of the Self and Family premium for that time period; both parent and covered only for care received from Plan providers, except for emergency benefits.

- You will not be informed by your employing office (or your retirement system) or your Plan when a member loses eligibility.

- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or eligible for coverage, to your employing office or retirement system. The Plan does not determine el cannot change an enrollment status without the necessary information from the employing agency o system.

- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive bene other FEHB plan.

- Report additions and deletions, including divorces, of covered family members to the Plan promptly

General Information *continued*

Things to keep in mind
continued

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

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

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

  Contact your local Social Security Administration (SSA) office for information on local Medicare p (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-68 your retirement system for information on dropping your FEHB enrollment and changing to a Medi plan.

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

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employ member may also be eligible for one of the following:

Former spouse coverage

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

Temporary continuation of coverage (TCC)

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

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

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

General Information *continued*

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

Notification and election requirements

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

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

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

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

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

Conversion to individual coverage

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

Certificate of Creditable Coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a C Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certi receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of tin condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate au you must be given one on request.

Facts about this Plan

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

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provi network. You cannot change plans because a provider leaves the HMO.

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

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive inform Plan, you can obtain it by calling the Carrier toll free at 888-563-2250 or you may write the Carrier at W Advantage, 1331 Garden Highway, Suite 100, Sacramento, California, 95833-9754. You may also conta fax at 916-563-3182, at its website at: http://www.westernhealth.com or by email at FEHB@westernheal

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If non reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confide transfer of medical records.

Who provides care to Plan members?

Western Health Advantage is a group model comprehensive medical plan (HMO) with doctors who treat group practice arrangement at multiple convenient locations near your home or office. Our family docto quality basic medical care and routine services for you and your family. Our plan doctors work closely v extensive network of local specialty physicians and have access to a complete referral resource for your WHA features some of the region's premiere medical professionals, giving our members access to more primary care doctors and more than 850 specialty care providers. WHA also maintains a complete netw physicians who have admitting privileges at some of the top facilities in the region. All non-emergency accessed through your primary care doctor. He/she is responsible for coordinating your health care with other medical providers. To give you more flexibility in choosing medical specialists, WHA offers you specialty physicians in the WHA network, not just those that who are affiliated with your primary doctor group. This benefit gives you greater choice in the selection of specialty physicians.

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

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. important since it is through this doctor that all other health services, particularly those of specialists, are the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan befor to a specialist or making arrangements for hospitalization. Services of other providers are covered only been referred by your primary care doctor, with the following exceptions: a woman may see her Plan gy her annual routine examination without a referral, and every member may self-refer to a Plan provider fo exam and refraction.

Facts about this Plan *continued*

Choosing your doctor

The Plan's provider directory lists primary care doctors (family practitioners, pediatricians and internists, instances obstetrician/gynecologists), with their locations and phone numbers. Directories are updated tw are available at the time of enrollment or upon request by calling the Membership Services Department a 2250; you can also find out if your doctor participates with this Plan by calling this number. If you are in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or participates with the Plan and is accepting new patients. Important note: **When you enroll in this Plan services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed**.

If you enroll, you will be asked to let the Plan know which primary care doctor(s) you've selected for yo member of your family by sending a Primary Care selection form to the Plan. If you need help choosing the Plan.. Members may change their doctor selection monthly by notifying the Plan 30 days in advanc of the family may choose their own primary care doctor from the complete list of participating primary c

If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services ur arrange with you for you to be seen by another participating doctor. The Member Service Department w letter letting you know that you need to choose a new primary care doctor. If you are unable to choose, t Services Department will assign one for you which you may change with notice to the Member Services 1-888-563-2250. Once a new primary care doctor has been assigned to you, WHA will issue a new ID ca the physician's name. In most cases, the effective date is the first day of the month following notificatio

Referrals for specialty care

Except in a medical emergency, or when a primary care doctor has designated another doctor to see his c you must receive a referral from your primary care doctor before seeing any other doctor or obtaining sp except for women seeing participating OB/GYN doctors. Referral to a participating specialist is given at care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will a appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor a consultation unless your doctor authorizes additional visits. All follow-up care must be provided or auth primary care doctor. Do not go to the specialist for a second visit unless your primary care doctor has ar referral in advance.

Advantage Referral

In order to expand the choice of specialists, WHA has implemented a unique program which affords you specialists in the network, rather than just those which have a direct relationship with your primary care c primary care doctor determines that your medical condition requires specialty care, you will be referred t provider. You may, however, request to be referred to any of the WHA network specialists. If you alrea relationship with a network specialist, or prefer another participating specialist, you may ask to be referre Your primary care doctor will provide a written or verbal referral to your selected specialist which includ the referral, such as number of visits ordered by your physician.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist freq primary care doctor will develop a treatment plan with you and your health plan that allows an adequate access visits with that specialist. The treatment plan will permit you to visit your specialist without the n further referrals.

Authorizations

The Plan will provide benefits for covered services only when the services are Medically Necessary to pr or treat your illness or condition. Certain covered services require Prior Authorization by WHA in order This means that your Primary Care Doctor must contact WHA, or in some cases, the participating medic affiliated with your Primary Care Doctor to request that the service or supply be approved for coverage b rendered. Requests for Prior Authorization will be denied if the requested services are not Medically Ne determined by WHA and your physician.

Facts about this Plan *continued*

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral f primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you to th now your Plan primary care doctor, you need only call to explain that you are now a Plan member and as referred for your next appointment.

If you are selecting a new primary care doctor and want to continue with this specialist, you must schedu appointment so that the primary care doctor can decide whether to treat the condition directly or refer yo specialist.

Hospital care

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

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainde year after your out-of-pocket expenses for services provided or arranged by the Plan reach $750 per Self or $1,500 per Self and Family enrollment. This copayment maximum does not include charges for Dura Equipment and prescription drugs.

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

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the January 1, any expenses that would have applied to that plan's deductible will be covered by your old pla care you got in January before the effective date of your coverage in this Plan. If you have already met t full, your old Plan will reimburse these covered expenses. If you have not met it in full, your old Plan w your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional cov The old Plan will pay these covered expenses according to this year's benefits. Benefit changes are effec

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. pay benefits for claims submitted later than December 31 of the calendar year following the year in whic was incurred unless timely filing was prevented by administrative operations of Government or legal inc the claim was submitted as soon as reasonably possible.

Experimental / investigational determinations

If not previously determined, the subject matter is experimental if:

a) It requires approval by the Federal Government or by the State government prior to use and where suc approval has not been granted at the time of use; or

b) It is not recognized or approved as a generally accepted professional medical standard in the national community as being safe and effective for use in the treatment of the condition , but nevertheless is autho testing, trials, or other studies on humans; or

c) It is used as part of a research protocol or clinical trial.

All experimental/investigational requests received by the Member's Medical Group Medical Manageme immediately forwarded to the WHA Medical Management Department for immediate attention and revie Medical Director.

The WHA Medical Director solicits the advice of health care professionals, peer review panels or comm the safety and effectiveness of evolving medical technologies and uses these recommendations in review experimental therapies and coverage determination.

Facts about this Plan *continued*

Experimental / investigational determinations
continued

All requests for experimental or investigational therapies are reviewed by the WHA Medical Director as external, independent review organization at the discretion of the WHA Medical Director.

All Members meeting the requirements for an external independent review are given notification in writi opportunity to request the external independent review within five business days of a decision to deny co experimental/investigational procedure/therapy.

Other considerations

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

The Plan's service area

The service area for this Plan, where Plan providers and facilities are located, is described below. You m in the service area to enroll in this Plan.

The service area for this Plan includes the following areas:

All of Sacramento and Yolo Counties, portions of Solano County (zip codes shown below) and Western

Solano zip codes: 94512, 95620, 95625, 94533, 94571, 94585, 94535, 95687, 95688, 95696

Benefits for care outside the service area are limited to emergency services, described on page 16.

If you or a covered family member move outside the service area, you may enroll in another approved pl necessary to wait until you move or for the open season to make such a change. Contact your employing retirement system for information if you are anticipating a move.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan**. This brochure is the official statement of benefits on which you can rely.

Circumstances beyond Plan control

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

Arbitration of claims

Any claim for damages for personal injury, mental disturbance or wrongful death arising out of the rendi to render services under this contract must be submitted to binding arbitration.

Other sources of benefits

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

General Limitations *continued*

Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part A and/or Part B, the Plan w benefits according to Medicare's determination of which coverage is primary. However, this Plan will n except those for emergencies, unless you use Plan providers. You must tell your Plan that you or your fa eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need claim.

Group health insurance and automobile insurance

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

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

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefi payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full or (2) a redu which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. Th of which health coverage is primary (pays its benefits first) is made according to guidelines provided by Association of Insurance Commissioners. When benefits are payable under automobile insurance, includ automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for healt without regard to other health benefits coverage the enrollee may have. This provision applies whether c filed under the other coverage. When applicable, authorization must be given to this Plan to obtain inforn benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

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

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any n are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This pr applies when a third party injury settlement or other similar proceeding provides medical benefits in rega under workers' compensation or similar laws. If medical benefits provided under such laws are exhauste financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitl reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Servi seek reimbursement from the Plan for certain services and supplies provided to you or a family member reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other lo Federal Government agency.

General Limitations *continued*

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Pla be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it the person's rights to the extent of the benefits received under this Plan, including the right to bring suit i name. If you need more information about subrogation, the Plan will provide you with its subrogation p

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will no covered for you unless your Plan doctor determines it is Medically Necessary to prevent, diagnose or treat your illness or condition and the Plan agrees, as discussed under Authorizations on page 11.** The following are excluded:

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

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and providers. This includes all necessary office visits; **you pay** a $5 office visit copay, but no additional co laboratory tests and X-rays. Within the service area, house calls will be provided if, in the judgment of t such care is necessary and appropriate. **You pay** a $5 copay for a doctor's house call. There is no charg by nurses or health aides.

The following services are included and are subject to the office visit copay unless stated otherwise:

- Preventive care, including well-baby care (no charge birth to two years) and periodic check-ups.
- Annual eye exams, including eye refraction, and hearing exams, for all ages.
- Mammograms are covered as follows: for women age 35 through 39, one mammogram during these women age 40 and over, every year. In addition to routine screening, mammograms are covered wh the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters are covered at no charge.
- Consultations by specialists.
- Diagnostic procedures, such as laboratory tests and X-rays are covered at no charge.
- Chemotherapy, radiation therapy, and inhalation therapy.

What is covered
continued

- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postn doctor. Copays are waived for maternity care. The mother, at her option, may remain in the hospital after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if M Necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided a under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of hospital confinement for maternity will be covered under either a Self Only or Self and Family enrol of an infant who requires definitive treatment will be covered only if the infant is covered under a Se enrollment.

- Voluntary sterilization and family planning services, including the insertion of intrauterine devices ($5 per visit. Norplant and other internally implanted time-release contraceptives are covered at a co One insertion is covered every five years. Voluntary removal prior to the five year expiration is not
- Diagnosis and treatment of diseases of the eye.
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum).
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- All non-experimental transplants including, cornea, heart, heart/lung, lung (single and double), kidn liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lympho advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, brea multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian Transplants are covered when approved by the Medical Director. Related medical and hospital exp are covered when the recipient is covered by this Plan.
- Patients who undergo mastectomies may, at their option, have this procedure performed on an inpati remain in the hospital up to 48 hours after the procedure.
- Dialysis.
- Surgical treatment of morbid obesity.
- Orthopedic devices, such as braces; foot orthotics when determined to be medically necessary; **you** p charges.
- Prosthetic devices, such as artificial limbs and lenses following cataract removal; **you pay** 20% of cl
- Durable medical equipment, such as standard wheelchairs and hospital beds; oxygen and oxygen eq **pay** 20% of charges.
- Chiropractic services for spinal manipulation, upon referral by a Primary care doctor, up to 20 visits with a $15 copayment per visit.
- Acupuncture for pain management, upon referral by a Primary care doctor, up to 20 visits per calend $15 copayment per visit.
- Home health services of nurses and health aides, including intravenous fluids and medications, whe your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and o providers, at no additional cost to you.

Medical and Surgical Benefits *continued*

Limited benefits

Oral and maxillofacial surgery is provided for non-dental surgical and hospitalization procedures for c defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adja cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. A involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care inv treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or fro or surgery that has produced a major effect on the member's appearance and if the condition can reasona be corrected by such surgery.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or ou basis for up to two consecutive months per condition if significant improvement can be expected within **pay** $5 per outpatient session. Speech therapy is limited to treatment of certain speech impairments of or Occupational therapy is limited to services that assist the member to achieve and maintain self-care and i functioning in other activities of daily living.

Diagnosis and treatment of infertility is covered, with prior authorization, including consultations, examinations, diagnostic surgical services related to hospitalizations or facilities, and fertility drug therap 50% of the charges. The cost of donor sperm is not covered. The following types of artificial inseminat intra vaginal insemination (IVI); intra cervical insemination (ICI), and intrauterine insemination (IUI). S include one gamete interfallopian transfer ("GIFT") or one in-vitro fertilization (IVF) but only one of the covered per Lifetime. Zygote interfallopian transfers are excluded. Other assisted reproductive technolo procedures, such as embryo transfer, are not covered.

Sexual dysfunction treatment is covered. **You pay** 50% of charges for durable medical equipment, dev drugs associated with treatment. Drugs are payable under the Prescription Drug benefit provision.

Penile Prostheses are limited to those prescribed by a plan doctor and determined to be Medically Nece secondary to penile trauma, tumor, or physical disease to the circulatory system or nerve supply, and are psychological cause. **You pay** 50% of charges.

Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infraction is provided for up to 36 sessions; **you pay** $5 per outpatient visit.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtainir employment or insurance, attending school or camp, or travel.
- Reversal of voluntary, surgically-induced sterility.
- Surgery primarily for cosmetic purposes.
- Homemaker services.
- Hearing aids.
- Long-term rehabilitative therapy, or custodial care.
- Infant formulas.
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsighte farsightedness (hyperopia) and blurred vision (astigmatism).
- Penile Prostheses are excluded unless you meet the above criteria.

Hospital/Extended Care Benefits

What is covered

Hospital care

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

- Semi-private room accommodations; when a Plan doctor determines it is Medically Necessary, the c
  prescribe private accommodations or private duty nursing care.
- Specialized care units, such as intensive care or cardiac care units.

Extended care

The Plan provides a comprehensive range of benefits with no dollar limit for up to 100 days per calendar
full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appr
determined by a Plan doctor. **You pay** nothing. **All necessary services are covered,** including:

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

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.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited benefits

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatme
conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor d
outpatient management is not medically appropriate. See page 18 for nonmedical substance abuse benef

What is not covered

- Personal comfort items, such as telephone and television.
- Custodial care, rest cures, domiciliary or convalescent care.

Emergency Benefits

What is a medical emergency?

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

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if yo contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nea emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can n You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do responsibility to ensure that the Plan has been notified in a timely manner.

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

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

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

Plan pays . . .

Reasonable charges for emergency services to the extent the services would have been covered if receive providers.

You pay . . .

$50 per hospital emergency room visit or $15 per urgent care center visit for emergency services that are of this Plan. If the emergency results in admission to a hospital, the copay is waived.

Emergencies outside the service area

Benefits are available for any Medically Necessary health service that is immediately required because o unforeseen illness.

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

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

Plan pays . . .

Reasonable charges for emergency services to the extent the services would have been covered if receive providers.

You pay . . .

$50 per hospital emergency room visit for emergency services that are covered benefits of this Plan. If t results in admission to a hospital, the copay is waived.

Emergency Benefits *continued*

What is covered

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

What is not covered

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

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upor claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay submit itemized bills and your receipts to the Plan along with an explanation of the services and the iden information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the contract on which denial was based. If you disagree with the Plan's decision, you may request reconside accordance with the disputed claims procedure described on page 17.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

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

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

Outpatient care

Up to 20 outpatient visits to Plan doctors or other psychiatric personnel each calendar year; **You pay** a $ each covered visit, and all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year; you pay nothing for the first 30 days -- all charges th days may be exchanged for outpatient (or day care) treatment/visits at a rate of 2 day treatments/visits fo day.

What is not covered

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

Mental Conditions/Substance Abuse Benefits *continued*

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, nc aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

Up to 20 outpatient visits to Plan providers for treatment each calendar year; **you pay** a $20 copay for ea and all charges thereafter.

Inpatient care

Up to 30 days per calendar year in a substance abuse rehabilitation (intermediate care) program in an alc rehabilitation center approved by the Plan; **you pay** nothing for the first 30 days–all charges thereafter.

What is not covered

Treatment that is not authorized by a Plan doctor

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispen 30-day supply. **You pay** a $5 copay per prescription unit or refill for generic drugs or $10 copay per pre name brand drugs on the Preferred Drug (formulary) list, or $15 copay per prescription for Non-Preferre Brand Name Medications per each 30-day supply or 120-unit supply, whichever is less. In no event wi the cost of the prescription drug, unless you request the brand name drug. When generic substitution is p generic drug is available and the prescribing doctor does not require the use of a name brand drug), but y name brand drug, you pay the price difference between the generic and name brand drug as well as the $ prescription unit or refill.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's formulary policy. Nonformulary drugs will be covered when prescribed by a Plan doctor.

WHA Preferred Drug (Formulary) List Development

The WHA Pharmacy and Therapeutics (P&T) Committee developed a Preferred Drug List (PDL) based and Cost Effectiveness. The Committee did not consider pharmaceutical rebates in this process. The grou clinical efficacy, safety profile and alternatives within the drug category. Lastly, the committee looked at The P&T Committee felt that a limited number of the medications on the Preferred Drug List should hav authorization for clinical or benefit reasons.

The Benefits for most members were then based on a three-tier co-pay. (Ex. Generic $5, Brand on the PI on the PDL $15). For every medication that is not on the Preferred Drug List, there are reasonable altern the Preferred Drug List. The Pharmacy and Therapeutics Committee felt that this approach to a pharmac leave more of the clinical decision making up to the treating physician. The differential co-pay for medic on the PDL simply took into account the added cost of some medications when good alternatives are ava

Covered medications and accessories include:

- Drugs for which a prescription is required by law.
- Oral and injectable contraceptive drugs.
- Contraceptive devices including diaphragms; IUDs are covered under Medical/Surgical Benefits.
- Insulin; a copay charge applies to each vial.
- Disposable needles and syringes needed to inject covered prescribed medication.

Prescription Drug Benefits *continued*

What is covered
(continued)

- Smoking cessation drugs and medication, including nicotine patches are covered as a "Wellness Ben obtain a prescription from your primary care doctor and are responsible for 100% of the cost of the r remaining smoke-free for 90 days after treatment as certified by your physician, WHA will reimburs You must be an active participant in WHA at the time of the reimbursement.
- Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's so equivalent, and acetone test tablets.
- Inhalers (limited to two per prescription).
- Fertility drugs; you pay 50% of charges.

Intravenous fluids and medication for home use, implantable drugs, such as Norplant, and some injectab Depo Provera, are covered under Medical and Surgical Benefits.

Limited benefits

Sexual dysfunction drugs have dosage limitations and you pay 50% of charges. Contact the plan for deta

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available.
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies.
- Vitamins and nutritional substances that can be purchased without a prescription.
- Medical supplies such as dressings and antiseptics.
- Drugs for cosmetic purposes.
- Drugs to enhance athletic performance.

Other Benefits

Dental Care

What is covered

Accidental injury benefit. Restorative services and supplies necessary to promptly repair (but not repla natural teeth. The need for these services must result from an accidental injury. **You pay** nothing.

What is not covered

Any other dental service not shown as covered.

Vision care

What is covered

In addition to the medical and surgical benefits provided for the diagnosis and treatment of diseases of th refractions (to provide a written lens prescription) may be obtained from Plan providers. **You pay** a $ 5

What is not covered

- Corrective lenses or frames
- Eye exercises.

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Member Se
(888) 563-2250 or you may write to the Plan at Western Health Advantage, 1331 Garden Highway, Suit
California 95833. You may also contact the Plan by fax at (916) 563-3182, at its website at http://www.
or by email at FEHB@westernhealth.com.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six
of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be exte
you were prevented by circumstances beyond your control from making your request within the time lim
review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your cla
request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the
payment or service should have been paid or provided.

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

OPM review

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

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

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal couns
interested parties may act as your representative only with your specific written consent to pursue payme
claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this bro
the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered
than one unrelated claim, clearly identify the documents for each claim.

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

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

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

OPM review
continued

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contr
P.O. Box 436, Washington, D.C. 20044.

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

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

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

Notes

Summary of Benefits for Western Health Advantage - 1999

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

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without a dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if Medically Necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing . . .	**15**
	Extended care	All necessary services up to 100 days in a calendar year. **You pay** nothing . . .	**15**
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per calendar year. **You pay** nothing . . .	**17**
	Substance abuse	Up to 30 days per calendar year in a substance abuse treatment program. **You pay** nothing . . .	**18**
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialists' care; preventive care, including well-baby care, periodic checkups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $5 copay per office visit; copays are waived for maternity care . . .	**12-14**
	Home health care	All necessary visits by nurses and health aides. **You pay** nothing . . .	**13**
	Mental conditions	Up to 20 outpatient visits per calendar year. **You pay** a $20 copay per visit . . .	**17**
	Substance abuse	Up to 20 outpatient visits per calendar year. **You pay** a $20 copay per visit . . .	**18**
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $50 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan . . .	**16**
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5/10/15 copay per prescription unit or refill for 30 days supply . . .	**18**
Dental care		Accidental injury benefit; **You pay** nothing . . .	**19**
Vision care		One refraction annually. **You pay** a $5 copay per visit . . .	**19**
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $750 per Self Only or $1500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include charges for durable medical equipment and prescription drugs . . .	**9**

1999 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 that maintains your health benefits enrollment.

Postal rates apply to most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain sp categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHE

		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	$57.83	$19.27	$125.29	$41.76	$68.43	$8.67
Self and Family	5Z2	$138.77	$46.25	$300.66	$100.22	$164.21	$20.81