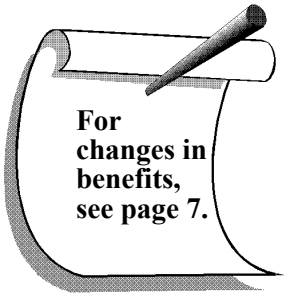
New West Health Services

http://www.newwesthealth.com

2009

A Health Maintenance Organization and point of services product

Serving:Anaconda, Big Timber, Big Sandy, Billings, Bozeman, Choteau, Columbus, Deer Lodge, Dillon, Forsyth, Great Falls, Hamilton, Hardin, Harlowtown, Havre, Helena, Jordan, Kalispell, Libby, Livingston, Malta, Miles City, Missoula, Philipsburg, Plains, Polson, Red Lodge, Ronan, Roundup, Shelby, Superior, Townsend, and Whitefish in Montana.



Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.

Enrollment code for this Plan:
NV1 High Option - Self Only
NV2 High Option - Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

RI 73-821

Important Notice from New West Health Services About
Our Prescription Drug Coverage and Medicare

OPM has determined that the New West Health Services' prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

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Introduction

This brochure describes the benefits of New West Health Services under our contract (CS 2873) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for New West Health Services administrative offices is:

New West Health Services
130 Neill Avenue
Helena, MT 59601

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language 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 New West Health Services.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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 U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800/290-3657 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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 pay only the copayments, coinsurance, and deductibles 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.

General features

You are generally covered for medically necessary, covered health services. You may receive the medically necessary covered health services listed below.

- Medical Office visits
- Preventive Health Services, including Well Baby and Well Child Care, routine periodic preventive health examinations, immunizations, allergy testing and treatment, and allergy serum
- Emergency services
- X-ray and Laboratory services
- Acute Inpatient Hospital Services
- Maternity, Pregnancy and Newborn Care
- Inpatient Physician Services and Consultations
- Outpatient Hospital services
- Outpatient Surgery
- Home Health Care
- Skilled Nursing Facility Services
- Mental Health Services
- Inpatient Chemical Dependency Services
- Inpatient Alcohol Treatment
- Durable Medical Equipment and Prosthetic Devices
- Orthopedic Appliances
- Outpatient Rehabilitative Therapy
- Oral Surgery

We have Point of Service (POS) benefits

Our HMO offers POS benefits. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may have higher out-of-pocket costs than our in-network benefits. See section 5 (i).

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 deductible, copayments or coinsurance. See Section 5 (j), Point of Service Benefits.

Your rights

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

- New West Health Services has been serving Montanan's since 1996.
- New West Health Services is a not for profit Health Services Corporation

Your medical and claims records are confidential

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

If you want more information about us, call 1-800-290-3657, or write to Member Services, New West Health Services, 130 Neill Ave Helena, MT 59601. You may also contact us by fax at 406-457-2299 or visit our website at www.newwesthealth.com

Service Area

To enroll in this Plan, you must live in and or work in our Service Area. This is where our providers practice. Our service area consists of: The area within a 30 mile radius of the following Montana cities: **Anaconda, Big Timber, Big Sandy, Billings, Bozeman, Choteau, Columbus, Deer Lodge, Dillon, Forsyth, Great Falls, Hamilton, Hardin, Harlowtown, Havre, Helena, Jordan, Kalispell, Libby, Livingston, Malta, Miles City, Missoula, Philipsburg, Plains, Polson, Red Lodge, Ronan, Roundup, Shelby, Superior, Townsend, and Whitefish in Montana.**

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. Other health care services out of our service area unless the services have prior plan approval will apply to the Point of Service rider, at a reduced benefit.

If you or a covered family member moves 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. However, if your dependents live out of the area New West Health Services has an arrangement with a National Network of Providers. If you or a family member moves, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2009

Do not rely only on these change descriptions; this Section 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.

Changes to this Plan

- United States Postal Service non-law enforcement career employees may now be covered either by Postal Category 1 or Postal Category 2 premium rates. See page 65.
- Your share of the non-Postal premium will increase for Self only or increase for Self and Family. See page 64.
- We updated our transplant coverage list to inlcude the following:
  - Blood or marrow stem cell transplants limited to the stages of the diagnosis:
    - Allogenic transplants for

Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)

Hemoglobinopathy (i.e., Fanconi's, Thalessemia major)

Myelodysplasia/Myelodysplastic syndromes

Amyloidosis

    - Autologous transplants for

Neuroblastoma

Amyloidosis

    - Autologous tandem transplants for

Recurrent germ cell tumors (inlcuding testicular cancer)

Multiple Myeloma

De-novo Myeloma

  - Blood or marrow stem cell transplants for
    - Allogenic transplants for

Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)

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 electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800/290-3657 or write to us at 130 Neill Avenue, Helena, MT 59601. You may also request replacement cards through our Web site: www.newwesthealth.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay co-payments, deductibles, and/or coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more.

- **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 Web site.

- **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 Web site.

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. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a family practitioner, internist, pediatrician. Your primary care physician will provide most of your health care.

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

- **Specialty care**

You may see any Specialist within the New West Health Services Network without a referral from your primary care physician. Your Primary Care physician should be kept involved in your health care treatment.Here are some other things you should know about specialty care:

- Here are some other things you should know about specialty care:

  · 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. If the specialist is a non-participating provider those services will apply to the Point of Service benefit.

  · 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 and 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 program 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 hospitalized when your enrollment begins**

  We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800/290-3657. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

  These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment .

How to get approval for…

- **Your hospital stay** — Authorization is required if you are hospitalized immediately following emergency care or urgent care. You must request precertification as soon as reasonably possible, preferably on the same or next business day. If you fail to timely notify New West Health Services of your hospitalization, any request for precertification of your hospital stay may be denied and you may lose benefits for the health care services you receive during your hospitalization. Precertification may be requested from Medical Services in writing at 130 Neill Avenue, Helena, MT 59601, by telephone 800-290-3657 or by facsimile at 406-457-2298.
- **How to precertify an admission** — Pre-certification is required if you are hospitalized immediately following emergency care or urgent care. You must request pre-certification as soon as reasonably possible, preferably on the same or next business day. If you fail to timely notify New West Health Services of your hospitalization, any request for pre-certification of your hospital stay may be denied and you may lose benefits for the health care services you receive during your hospitalization. Pre-certification may be requested from Medical Services in writing at 130 Neill Avenue, Helena, MT 59601, by telephone 800-290-3657 or by facsimile at 406-457-2298.
- **Maternity care** — Pre-certification is required for any hospital stay in excess of 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery. Pre-certification may be requested from Medical Services in writing at 130 Neill Avenue, Helena, MT 59601, by telephone 800-290-3657 or by facsimile at 406-457-2298.
- **What happens when you do not follow the precertification rules when using non-network facilities** — Any health care services received that require precertification will be denied.

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 pre-certification or pre-certification. Your physician must obtain pre-certification when the following are true.

- Any referral for in or out patient care where the provider is not a member of New West Health Services' provider network.
- A member is to be confined in a hospital, mental health or chemical dependency facility, skilled nursing facility, rehabilitation facility, or other institution, whether in-network or out-of-network.
- A member requires Durable Medical Equipment, prosthetic devices or implants.
- Home Health Services
- A member requires rehabilitation or therapy.
- Non-emergency care air ambulance service (including related ground ambulance service).
- A second and any subsequent ultrasounds
- Ground ambulance for a non-emergency care transfer from one facility to another facility.
- Neuropsychiatric and neuropsychological testing.

If the services are to be provided by a Participating Provider, the Participating Provider will perform any necessary pre-certification process. If the services are to be provided by a Non-Participating Provider, the member is responsible to obtain pre-certification, or ensure that the Non-Participating Provider performing such services obtains the necessary pre-certification which will include the following information:

- The Member's name and group number
- The attending Physician's name, telephone number
- The name address, and phone number of the facility the services are to be performed, if applicable
- The exact services to be performed and justification of the medical Necessity of such services
- The scheduled date for services. Pre-certification must be requested at least seven (7) working days prior to any In- Network scheduled service or procedure and 15 working days prior to any Out-of-Network service or procedure. If New West Health Services does not pre-certify a service by an Out-of Network Provider, the service will not be covered.

New West Health Services will provide verbal or written notification to the Member and the Participating Provider verifying or denying such pre-certification or authorization. Should the Member disagree with the decision, the member may appeal.

Section 4. Your costs for covered services

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

Copayments

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

Example: When you see your primary care physician you pay a copayment of $15 per office visit and when you go in the hospital, you pay $100 per admission.

Cost-sharing

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

The calendar year deductible is $250 per person under this plan. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $500 under this plan.

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

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

In any circumstance in which a provider's billed charges are less than the plan allowance for the covered services provided (after adjustment for special circumstances, as described previously), New West Health Services will pay the provider the provider's billed charges.

Participating Provider

A participating provider agrees to accept New West Health Services' plan allowance as payment in full for covered services. You and New West Health Services collectively pay the plan allowance as follows:

- You pay directly to the participating provider any copayments, deductibles and/or coinsurance required for the covered services you received under the terms of this benefits booklet and the plan's schedule of benefits.
- New West Health Services pays the rest of the plan allowance (in other words, the plan allowance less the payments you are required to make).

If a participating provider erroneously charges you a fee for covered services in excess of the copayments, deductibles and/or coinsurance specified in this booklet's schedule of benefits, you should immediately contact New West Health Services or the participating provider for correction of the charge. You are responsible for paying the participating provider billed charges, unless you otherwise negotiate with the provider, for any health care services that are not covered services.

Non-Participating Providers

New West Health Services will pay the plan allowance for the covered services less any copayments, deductibles and/or coinsurance specified in the point-of-service product on page 44.

Your catastrophic protection out-of-pocket maximum

After your copayments and coinsurance total $1500 per self only or $3000 per family enrollment in any calendar year, you do not have to pay any more for covered services.

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

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill Us

Facilities of the Department of Vertans Affairs, the Department of Defense, and the Indian Health Services are entitled to seek reimbursement from the certain services and supplies they provide to you or a family member. They may not seek more than the governing laws allow.

Section 5. Benefits

See page 7 for how our benefits changed this year. See page 63 for a benefits summary. Make sure that you review the benefits that are available under the option in which you are enrolled.

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

***Important things you should keep in mind about these benefits*:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is: $250 per person ($500 per family). Most of the benefits in this section do not apply to deductible. *We added "(Calendar year deductible applies)" to show when the calendar year deductible applies.*

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.

Benefit Description	You pay
Note: The calendar year deductible applies only when we say below: "(Calendar year deductible applies)"	
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$15 per office visit $15 per visit to your primary care physician $15 per visit to a specialist *Procedures, lab and x-ray services are subject to annual deductible and coinsurance.*
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultation • Second surgical opinion	$15 per visit $15 per visit $15 per visit If requested by the member: 100% If requested by the New West Health Services: Nothing.
At home	$30 per home visit
Not covered: • *Hearing aids and related services.* • *Reverse sterilization services.*	*All charges*
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms	20% coinsurance (Calendar year deductible applies.) $100 co-pay for labs performed at a hospital or in an ambulatory surgical center. (See Section 5(c))

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	
• CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	20% coinsurance (Calendar year deductible applies.) $100 co-pay for labs performed at a hospital or in an ambulatory surgical center. (See Section 5(c))
Preventive care, adult	
Routine physical every year which includes: Routine screenings, such as: • Total Blood Cholesterol – one every three years • Colorectal Cancer Screening , including - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50	$15 per office visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	$15 per office visit
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see *Diagnostic and treatment services.*	$15 per office visit
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$15 per office visit
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	$15 per office visit
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*

Benefit Description	You pay
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$15 per office visit
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction (see section 5(j)) - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	$15 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 precertify your normal delivery; see page 10 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, (you do not need to precertify the normal length of stay). We will extend your inpatient stay for you or your baby if medically necessary . • Newborn charges are paid like any other member benefits, except the first newborn well child exam in the hospital is covered at 100%. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). We cover routine sonograms to determined fetal age, size and sex. Limits: • Pre-authorization is required for second and any subsequent ultrasounds. • Non-routine office visits or office visits not directly related to prenatal care are subject to all applicable copay, deductibles and/or coinsurance.	$50 Global copay for Prenatal Care $100 copay for hospital admission Postnatal care is subject to $15 per office visit

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	
Not covered: • *Amniocentesis, ultrasound or any other procedure intended solely for gender determination.* • *Birthing classes and/or services* • *Lactation classes and/or services, including breast pumps.* • *Genetic selection services.*	*All charges*
Family planning	
A range of voluntary family planning services, limited to: • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$15 copay per office visit. Procedures, lab and x-ray services are subject to annual deductible and coinsurance.
Surgical implantation of Intrauterine Devices (IUDs). (See Surgical procedures Section 5(b).) Surgical implantation of contraceptive devices. (See Surgical procedures Section 5 (b).)	$100 copay
Voluntary sterilization	You pay nothing for the first $300 of allowed charges, after that 20% coinsurance (Calendar year deductible applies.) This benefit is payable only once per lifetime.
Injectable contraceptive drugs (such as Depo provera)	20% coinsurance
Not covered: • *Reversal of voluntary surgical sterilization.* • *Genetic counseling.*	*All charges*
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) <u>Limits:</u> • Limited infertility services to the extent pre-certified by New West Health Services, including testing, appropriate medical advice, and instruction in accordance with accepted medical practice. • Treatment for infertility is covered only for Members who have been diagnosed as biologically infertile in accordance with accepted medical practice.	20% coinsurance (Calendar year deductible applies.)

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	
• Three artificial inseminations per Member per lifetime. If after 3 attempts per lifetime, the Member fails to conceive, no additional inseminations will be covered.	20% coinsurance (Calendar year deductible applies.)
Not covered: • *Fertility medications* • *Surrogate parentage* • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Gene manipulation therapy*	*All charges*
Allergy care	
• Testing and treatment	$15 per office visit (Any lab and/or x-ray charges are subject to the 20% coinsurance. (Calendar year deductible applies.)
• Allergy injections	20% coinsurance (Calendar year deductible applies.)
• Allergy serum	Nothing.
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 29. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT)	20% coinsurance (Calendar year deductible applies.)

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	
Note: Growth hormone is covered under the prescription drug benefit. Note: – We only cover GHT when we pre-authorize the treatment. Call the Pre-authorize line at 800-290-3657.	20% coinsurance (Calendar year deductible applies.)
Pulmonary therapy (15 visits per year combined with cardiac rehabilitation).	20% coinsurance (Calendar year deductible applies.)
Physical and occupational therapies	
For the following services: • qualified physical therapists and • occupational therapists • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction (15 visits per year combined with pulmonary therapy.) 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. Limits: • 60 visits annual benefit maximum (not combined) for physical therapy • 60 visits annual benefit maximum (not combined) for occupational therapy	20% coinsurance (Calendar year deductible applies.)
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	
• 60 visits annual benefit maximum	20% coinsurance (Calendar year deductible applies.)
Hearing services (testing, treatment, and supplies)	
• Audiology screenings (also, see Preventive care, children) • Hearing testing for children through age 17	20% coinsurance (Calendar year deductible applies.)
Not covered: • All other hearing testing • Hearing aids, testing and examinations for them • Cochlear Implants	*All charges*

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

Benefit Description	You pay
Hearing services (testing, treatment, and supplies) (cont.)	
Note: If a medically necessary surgery is required, New West Health Services will pay for the medically necessary surgery even though the implant is not covered.	*All charges*
Vision services (testing, treatment, and supplies)	
• Routine eye examinations (once per 12 months) for children through age 17 • One pair eyeglasses (lenses and frames per 12 month period) for children through age 17 • Note: See *Preventive care, children* for eye exams for children. • Annual eye refractions	$10 copay per examination (in-network), and up to $42 per examination (out-of-network). $100 limit (In-network and Out-of-Network)
One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	20% coinsurance (Calendar year deductible applies.)
Not covered: • Eyeglasses or contact lenses, except as shown above • *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.	20% coinsurance (Calendar year deductible applies.)
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*

Benefit Description	You pay
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. Limits: • Must be pre-certified by New West Health Services. • Prosthetics and Orthotics do not apply to Out-of-Pocket Maximum. (This means you will always pay coinsurance.)	20% coinsurance (Calendar year deductible applies.)
Not covered: • Orthopedic and corrective shoes • Arch supports • Foot orthotics • Heel pads and heel cups • Lumbosacral supports • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Cochlear Implants • Penile prostheses Note: If a medically necessary surgery is required, the New West Health Services will pay for the medically necessary surgery even though the implant is not covered.) • Prostheses for cosmetic purposes, dental braces, orthotic devices for podiatric use and arch support, braces used as aids in sports and activities, corsets and other non rigid appliances.	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches;	20% coinsurance (Calendar year deductible applies.)

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	
• Walkers; • Blood glucose monitors; and • Insulin pumps. • Pain control devices. • Oxygen concentrators. • Bone growth stimulators. • Customized braces. • Motorized transportation devices, including, but not limited to, motorized wheelchairs and scooters. • CPAP (continuous positive airway pressure) devices. • BiPAP (bilevel positive airway pressure) devices. • Oral devices (known as mandibular advancement devices) when a treatment trial using a CPAP or BiPAP device fails or is otherwise prohibited. Limits: • Durable Medical Equipment does not apply to Out-of-Pocket Maximum. (This means you will always pay coinsurance.) • $3000 annual benefit maximum. - Insulin pumps (rental/purchase) do not apply to the annual benefit maximum. • $500 annual benefit maximum for an oral device and related health care services for treatment of sleep apnea. • Must be prescribed by a Provider and pre-certified by New West Health Services in writing. • Member must provide proof of Medical Necessity. The pre-certification will be for specific DME and for a specific period of time. The pre-certification will state whether purchase or rental is approved. After the initial pre-certification period of Coverage expires, continuation of Coverage is subject to written pre-certification in advance for another specified period. Note: Call us at 800-290-3657 as soon as your Plan physician prescribes this equipment	20% coinsurance (Calendar year deductible applies.)
Not covered: • Environmental modification to home or place of residence. • Non prescribed or over the counter appliances.	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	
• Equipment for personal comfort, convenience or spare. • Penile prostheses (medically necessary surgery is covered), prostheses for cosmetic purposes, dental braces, orthotic devices for podiatric use and arch support, braces used as aids in sports and activities, corsets and other non rigid appliances. • Maintenance or replacement due to loss, theft or destruction of external prostheses. • Batteries or routine supplies needed for the operation or maintenance of the DME equipment purchased, includes, but not limited to, Oxygen tubing, CPAP and nebulizer filters. • Repair or maintenance of DME once purchased. • Breast Pump	*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. Limits: • Must be pre-certified by New West Health Services.	20% coinsurance (Calendar year deductible applies.)
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	
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Limits: $500 annual benefit maximum	$15 per office visit (Procedures, lab and x-rays are subject to the annual deductible and 20% coinsurance.*)*
Not covered:	*All charges*

Chiropractic - continued on next page

Benefit Description	You pay
Chiropractic (cont.)	
• Naturopathic services • Hypnotherapy • Biofeedback • Acupuncture	*All charges*
Alternative treatments	
No benefit.	*All charges*
Educational classes and programs	
Coverage is limited to: • Smoking cessation – Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. *Where available.* • Diabetes self management • Diabetic Counseling	$15 per office visit Anything beyond the first dollar coverage of $250

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is: $250 per person ($500 per family). The calendar year deductible applies to almost all benefits in this Section. *We added "(Calendar year deductible applies)" to show when the calendar year deductible applies.*
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Note: The calendar year deductible applies only when we say below: "(Calendar year deductible applies)"	
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 (bariatric surgery) Note: All of the five criteria below must be met in order for any of the procedures to be covered. However if your BMI is 40 or greater you don't need #2. If your BMI is = to or >35 you do need # 2 (co-morbidities). - Morbid obesity is present for greater than a five year period and is defined as BMI 40 alone or a BMI = or >35 with co-morbid conditions.	$100 copay (Calendar year deductible applies.)

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
- Significant medical conditions caused or aggravated by obesity are present including (co-morbid conditions): type II diabetes mellitus, poorly controlled hypertension, significant cardiopulmonary disorder, severe arthropathy of weight bearing joints, obstructive sleep apnea, dyslipidemia, and pseudotumor cerebri. - Alternative interventions have been tried, failed and documented for a minimum of a six month period. - The patient is an appropriate candidate for surgery having risks of surgery weighed against benefits. - The patient is an appropriate psychological candidate for surgery having been evaluated by a mental health professional. • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • 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.	
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; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as:	20% coinsurance (Calendar year deductible applies.)

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
- surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) 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. • Breast reduction surgery.	20% coinsurance (Calendar year deductible applies.)
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	
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; • Treatment of TMJ, including surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy; and • Other surgical procedures that do not involve the teeth or their supporting structures.	20% coinsurance (Calendar year deductible applies.)
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Benefit Description	You pay
Organ/tissue transplants	
Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Lung; Single, double or lobar • Kidney • Liver • Pancreas • Intestinal transplants - Small intestine - Small intestine with liver - Small intestine with multiple organs, such as the liver , stomach, and pancreas - Lung: single/bilateral/lobar	Nothing
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Hemoglobinopathy(i.e., Fanconi's, Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Neuroblastoma - Advanced non-Hodgkin's lymphoma - Advanced neuroblastoma - Amyloidosis • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Multiple Myeloma - De-novo Myeloma Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer New West Health Services requires the use of Centers of Excellence for transplants. (See Section 5 (h)). Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Mini-transplants (non-myeloablative, reduced intensity conditioning): Subject to medical necessity.	Nothing
Tandem transplants: Subject to medical necessity	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	20% coinsurance (Calendar year deductible applies.)

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. *We added "(Calendar year deductible applies)" when it applies.* The calendar year deductible is: $250 per person ($500 per family).
- 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 in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Note: The calendar year deductible applies only when we say below: "(calendar year deductible applies)".	
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.	$100 copay
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen	$100 copay
• 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 (Note: calendar year deductible applies.)	$100 copay
Not covered: • *Custodial care*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
• *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.	$100 copay
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
Extended care benefit: Extended care rehabilitation or Convalescent care services as follows: • Only on order of the Participating PCP or other qualified professional when pre-certified in writing by New West Health Services; • Only when care is in lieu of a Hospital Confinement. Note: Services include accommodations, meals, general nursing care, medical supplies and equipment ordinarily furnished by the facilities, and all prescribed drugs and biologicals <u>Limits:</u> • Extended care benefits/nursing care facility benefits are limited to a 60 days annual benefit maximum.	$100 copay per admission
Skilled nursing facility (SNF)	$100 copay per admission

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay
Extended care benefits/Skilled nursing care facility benefits (cont.)	
Not covered: • *Custodial care* • *Private duty nurse*	*All Charges*
Hospice care	
When a treatment plan is submitted to New West and approved and the care is provided by a Medicare or certified state licensed Hospice agency, services in a home or hospice facility include: • Nursing care provided by or under the supervision of a registered nurse. • Home health aide services under the supervision of a registered nurse or specialized rehabilitative therapist. • Respiratory therapy and inhalation services. • Nutrition counseling by a nutritionist or dietitian. • Individual, family and caregiver counseling. • Medical social services. • Bereavement support for Member's family. • Continuous home care or short-term inpatient care provided in a Participating Hospice inpatient unit, Hospital, or skilled nursing facility as required for pain control or symptom management. • Medical supplies ordinarily furnished by the hospice agency, including prescription drugs and biologicals. <u>Limits:</u> • For hospice care to be covered services, BOTH of the following requirements must be met: - The hospice care is provided by a Medicare or certified state licensed hospice care agency in your home or a hospice care facility. - Before your hospice care starts, NWHP receives and reviews the hospice care treatment plan developed by the physician, physician assistant or advance practice nurse ordering the hospice services, which must include, but is not limited to, a certification from that professional that you are in the terminal stages of illness, with a life expectancy of approximately 6 months or less. • Inpatient hospice care will be provided when either: - There are no suitable caregivers able to provide care in your home. OR	20% coinsurance (Calendar year deductible applies)

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	
- It is determined that hospice care at your home is impractical because your condition cannot be adequately managed in an outpatient setting by the person(s) who regularly assist with home care, including, but not limited to, pain medication management. • Respite care, limited to 5 consecutive days every 2 months.	20% coinsurance (Calendar year deductible applies)
Not covered: • Independent nursing, homemaker services. • Private duty nursing and private duty home health aides. • Health care services related to the terminal condition that are not a part of hospice care. • Services of a caregiver other than the one provided by the hospice care agency, including, but not limited to, someone who lives in your home or someone who is your relative. • Services that provide a protective environment where no medical or professional skill is required, including, but not limited to, companionship or sitter services. • *Services not directly related to your medical care, including, but not limited to, custodial care, maintenance care, domestic or housekeeping services, legal services, estate planning, funeral costs, Not covered: Independent nursing, homemaker services food services (including, but not limited to, meals on wheels), and transportation services other than covered ambulance services.*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate <u>Limits:</u> • Prior authorization is required for: - Non-emergency care air ambulance service (including related ground ambulance service). - Ground ambulance for a non-emergency care transfer from one facility to another facility.	$100 copay per trip (ground or air)

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per person ($500 per family). We added "(No deductible)" to show when the calendar year deductible does not apply

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.

What is a medical emergency?

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

What to do in case of emergency: Dial 911 or seek medical attention as soon as possible.

Emergencies within our service area

If a member receives Medically Necessary ground or air ambulance service when the destination is an Acute Care facility, for any of the following:

- Movement from the place where the Member was injured in an accident or became ill to a facility for treatment.
- If appropriate Medically Necessary care is not available at a Hospital or hospice, movement to the nearest Hospital where the Medically Necessary care may be given.

When ordered by the Member's attending Physician, movement from the Hospital to another facility or from the Member's home for Emergency situations.

Emergencies outside our service area:

If a Member receives Medically Necessary Emergency care outside the New West Health Services Service Area, the Member will be entitled to reimbursement for:

- Reasonable and Customary Charges for Hospital services that are Covered Services.
- Reasonable and Customary Charges for professional services that are covered Benefits, including sales tax in states where such tax is allowed by law.
- Reasonable and Customary Charges for transportation pre-certified by New West Health Services to return Member to a Participating Hospital, less the cost of Member's normal return trip expense.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital , including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$15 copay (No deductible) $15 copay (No deductible) $75 copay (No deductible) (Copay waived if admitted)
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$15 copay (No deductible) $15 copay (No deductible) $75 copay (No deductible) (waived if admitted)
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *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	
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	$100 copay per encounter (ground or air) (No deductible)

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

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.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. The calendar year deductible is: $250 per person ($500 per family). We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section.	
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 illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$15 per visit
• Diagnostic tests • Neuropsychiatric and neuropsychological testing is covered only in the case of a stroke or accidental injury to the brain and prior authorization is required.	20% Coinsurance (Lab and/or x-ray services subject to deductible and coinsurance)
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$100 copay per admission
Not covered: Services we have not approved.	*All charges*

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits (cont.)	
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*

Pre-certification	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes: Pre-certification may be requested from Medical Services in writing at 130 Neill Avenue, Helena, MT 59601, by telephone 800-290-3657 or by facsimile at 406-457-2298. See section 3
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no prescription drug 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.

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

- **Who can write your prescription.** A licensed provider or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy.
- **We use a formulary.** When accessing the Prescription benefit you will pay $10 for Generic Drugs, $20 for Brand Drugs that are on the formulary, and $40 for drugs that are not on the formulary.

We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 888-500-3355.

These are the dispensing limitations.

The Network Pharmacy Program will not provide you with drugs or medicine that exceeds a 34 day supply.

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available you will pay the 3rd tier copay ($40)

We offer a Mail order Pharmacy program where a member can access a 90 day supply of a medication for a 2 month copay, at appropriate tier. (generic $20, brand formulary $40, brand non-formulary $80)

- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

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 do have to file a claim.

Network pharmacies file your claims for you. You must file a claim when you use a non-network pharmacy. To obtain a claim form, call us at 1-800-290-3657 or access our website at www.newwesthealth.com.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Contraceptive drugs and devices • Diabetic supplies such as needles, syringes, and lancets fall under the pharmacy benefit.	$10 generic (No deductible) $20 brand formulary (No deductible) $40 brand non-formulary (No deductible) Note: If there is no generic equivalent available, you will still have to pay the brand name copay. If there is a generic available and you choose to use a brand name, your copay will be at the 3rd tier. Mail Order Prescriptions: With this program, you may receive up to a 90-day supply of prescription drugs, injectables and supplies (collectively referred to below as prescription drugs) through the mail. Your incentive to use this program is that you will pay 2 copayments for the 90-day supply, as opposed to 1 copayment for each 30-day supply through a retail pharmacy. Information about how to use this program is included in your enrollment packet. In addition, you may contact Customer Services for assistance with this program. (No deductible) $20 copay for diabetic test strips (No deductible)
Not covered: • Drugs and supplies for cosmetic purposes • Drugs to enhance athletic performance • Fertility drugs • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies • Vitamins, nutrients and food supplements even if a physician prescribes or administers them • Nonprescription medicines	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- The calendar year deductible is: $250 per person ($500 per family). The calendar year deductible applies to all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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. See Section 5(c) for inpatient hospital benefits. 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.

Accidental injury benefit	You pay
Accidental injury benefit	
We cover restorative service and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	20% coinsurance after deductible

Dental benefits	
We have no other dental benefits.	

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option , we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Referrals for Specialists	You are NOT required to obtain referrals to see specialists.
Out of State Benefits	New West Health Services has an agreement with a national provider network. This arrangement provides “in-network” benefits for dependents out of the State of Montana, such as the case of a College student or when there is court ordered coverage. Authorization is required to receive in-network benefits. To locate a provider go to http://www.newwesthealth.com/partprovider.htm.
High risk pregnancies	High Risk pregnancies are case managed by local patient care coordinators. Patient care coordinators are RN’s. We will refer patient to a center of excellence if appropriate.
Centers of excellence for transplants	New West Health Services requires the use of Centers of Excellence for transplants. The following transplant networks are available to choose from: Optum Health, Lifetrac, and Cigna's LifeSource.
Travel benefit/services overseas	New West Health Services Members are covered as if “in-network” for emergency services anywhere in the world.

Section 5(i). Point of Service benefits

Facts about this Plan's POS option

Under the point-of-service option, you may choose to obtain covered health services from non-Plan doctors and hospitals whenever you need care. When you obtain covered non-emergency medical treatment from a non-Plan doctor, you are subject to the deductible, coinsurance and out-of-pocket maximum stated below.

What is covered

Under the point-of-service benefit, you are covered for medically necessary, covered health services when you self-refer to a non-Plan provider. You may receive the medically necessary covered health services listed below, except for the services listed under "What is not covered." If you choose to use the point-of-service benefit, you will receive a lower allowance than when the standard HMO benefit is utilized. In addition, the non-Plan provider may bill you for any amounts not paid by the Plan.

- Medical Office visits
- Preventive Health Services, including Well Baby and Well Child Care, routine periodic preventive health examinations, immunizations, allergy testing and treatment, and allergy serum
- Emergency services
- X-ray and Laboratory services
- Acute Inpatient Hospital Services
- Maternity, Pregnancy and Newborn Care
- Inpatient Physician Services and Consultations
- Outpatient Hospital services
- Outpatient Surgery
- Home Health Care
- Skilled Nursing Facility Services
- Mental Health Services
- Inpatient Chemical Dependency Services
- Inpatient Alcohol Treatment
- Durable Medical Equipment and Prosthetic Devices
- Orthopedic Appliances
- Outpatient Rehabilitative Therapy
- Oral Surgery

Plan Precertification

When utilizing the POS benefit, we continue to require that you obtain prior medical review for the same services for which prior medical review is required under the standard HMO benefit. When utilizing non-Plan participating providers, it is recommended that you advise the provider to contact the Plan for prior medical review before services are provided.

Deductible

When the point-of-service benefit is utilized, you pay a $500 deductible per member per calendar year or a $1000 deductible per family per calendar year for all covered health services received from non-Plan providers. This deductible is separate from the deductible that applies under the standard HMO benefit, and will apply even if you have met your standard HMO benefit deductible. Coinsurance and copayments you pay under either the point-of-service benefit or the standard HMO benefit cannot be used to meet your calendar year deductible under the point-of-service benefit.

Coinsurance

If you use a provider who participates in our network, you will be responsible for the standard HMO benefit deductible and coinsurance, or the standard HMO copayment, whichever applies. If you use a provider who has not contracted with us, you will be responsible for the point-of-service deductible (described above), 30% coinsurance, and the remaining balance of the non-network provider's charges, if they are greater than the fee schedule or allowance amount. Copayments do not apply to point-of-service benefits.

For non-network health care professionals, laboratories, urgent care facilities, ambulatory surgical centers and durable medical equipment, your 30% coinsurance amount is determined from our fee schedule for non-network providers. Our fee schedule for non-network providers is based on, but lower than, the fee schedule for network providers. Both fee schedules are based on the "Resource-Based Relative Value Scale," a method for valuing health care services developed by Medicare. For non-network hospitals and other inpatient facilities, your 30% coinsurance is based on our allowance, which is determined by the nature of the services provided, the type of facility in which they were provided, and market data.

Please note that hospital charges, sometimes called facility charges, do not include any charges for doctors' services.

Out-of-Pocket Maximum

After your point-of-service deductible and coinsurance total $2,000 per person per calendar year or $4,000 per family per calendar year, you do not have to pay any more for covered services under the POS benefit. Charges over the fee allowance are not applied to the out-of-pocket maximum.

Emergency Benefits

Medically necessary emergency care (even if received from a non-participating provider) is always covered as a standard HMO benefit.

What is Not Covered

Services that are excluded from coverage under the standard HMO benefit also are excluded from coverage under the point-of-service benefit (other than services that are excluded under the standard HMO benefit only because they are provided by a non-network provider). Read Sections 5 and 6 about services that are not covered under the Plan.

Prescription drugs (covered under the standard HMO benefit; read Section 5(f) for more information).

Services that are experimental or investigational.

Services that are not medically necessary.

Services for which prior medical review is required, but is not obtained.

How to Obtain Benefits

If you receive services from a non-participating provider, the provider may file a claim directly with us. If the provider files a claim, payment generally will be made directly to the provider. However, we may pay you, even if the provider filed the claim. In that case, you are responsible for paying the provider. If the provider requires you to pay up front and will not submit a claim for you, you should submit a claim to us for reimbursement. See page 47 for instructions on how to file a claim. You must submit a complete claim form by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that Government administrative operations or legal incapacity prevented you from filing on time.

Section 5 (j). Vision Benefits

New West Health Services offers Vision Benefits through Vision Services Plan Insurance Company (VSP).

The vision benefits are as follows:

	You pay
Examination	
Routine Eye Exam (Once per 12-months)	In-Network $10 Copayment Out-of-Network The Plan will reimburse you up to $42 per exam*
Hardware Benefit (Lenses and Frames) (Once per 12-months)	In-Network The Plan will pay $100 towards the purchase of hardware Out-of-Network The Plan will reimburse you $100 towards the purchase of hardware*

How to Submit Claims

Participating providers will submit the claims for you.

*Members must submit claims for services received from non-participating providers directly to VSP for reimbursement. Assistance is available directly from the VSP Customer Service Department at 1-800-877-7195. Out-of-Network claims should be mailed to:

VSP
Attn: Out-of-Network Claims
P.O. Box 997105
Sacramento , CA 95899-7105

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergencyservices/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Items specifically listed as not covered in this brochure; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

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. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 800-290-3657.

When you must file a claim – such as for services you received outside the Plan's service area – 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: **New West Health Services, P.O. Box 548, Kalispell, MT 59901**

Sample claims forms are available by calling 800-290-3658 or at http://www.newwesthealth.com/agents1.htm**.**

Prescription drugs

Submit your claims to: Caremark, P.O. Box 52136, Phoenix, AZ 85072

Sample claims forms are available by calling 800-290-3658 or at http://www.newwesthealth.com/agents1.htm.

Other supplies or services

Submit your out-of-network vision claims to: VSP, Attn: Out-of-Network Claims, P.O. Box 997105, Sacramento, CA 95899-7105

Sample claims forms are available by calling 800-290-3658 or at http://www.newwesthealth.com/agents1.htm**.**

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 benefits for 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 pre-authorization/prior approval required by Section 3.

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: New West Health Services, 130 Neill Avenue, Helena, MT 59601; and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

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

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: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

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.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

a) We haven't responded yet to your initial request for care or precertification (preauthorization/prior approval), then call us at 800-290-3657 and we will expedite our review; or

b) We denied your initial request for care or precertification (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 may call OPM's Health Insurance Group HIG 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 or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault.

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

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

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

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

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

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

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.

If your Plan 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 will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

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

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-290-3658 or see our Web site atwww.newwesthealth.com.

We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: You may enroll in our New West Medicare Advantage plan and also remain enrolled in our FEHB plan.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

- **Medicare prescription drug coverage (Part D)**

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

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payer for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payer before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan,

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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. You may also be responsible for additional amounts. See page 12.

Copayment

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

Cost-sharing

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

Covered services

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or investigational service

Medical, surgical or psychiatric procedures, treatments, devices and pharmacological regimes (including investigational drugs and drug therapies) determined by the medical community at large, including the United States Food and Drug Administration, or Medicare, or recognized review sources (such as Hayes, DATTA, etc.) to be experimental, investigational or unproven. New West Health Services, in its sole discretion, shall have the authority to determine from time to time pursuant to the terms, conditions, and procedures set forth in Utilization Review Plan what are considered to be experimental, investigational, unproven, unusual, or not customary treatments, procedures, devices, and/or drugs.

Medically Necessary

"Medically Necessary" means those Covered Services, as determined by New West Health Services on a case-by-case basis, that are appropriate and necessary to meet basic health needs and/or improve the health status of a Member. To qualify as Medically Necessary, a Covered Service or supply must be:

- Not Experimental, Investigational, Unproven, Unusual or Not Customary Treatments, Procedures, Devices, and/or Drugs;
- Consistent with the diagnosis of and prescribed course of treatment for the Member's condition;
- Consistent with sound and valid standards for preventive care;
- Required to prevent the Member's condition from worsening;
- Consistent with the local medical standards of the community and considered appropriate for the Member's condition; and
- Performed in the most cost efficient type of setting appropriate for the condition.

The fact that a Physician has recommended, prescribed, or provided a Health Care Service or supply does not make the Health Care Service or supply a Medically Necessary Covered Service.

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 as follows:

Factors that New West Health Services considers in determining the allowed charge for a given covered service include (but are not limited to) the nature of the covered service, the type of provider and whether the provider is participating or non-participating.

The allowed charge for a covered service provided by a health care professional who is a participating provider is determined by a fee schedule included in that provider's participation agreement. Health care professionals are physicians, therapists, physician assistants, advance practice nurses and other providers who are individuals in single or group practice. New West Health Services bases its fee schedule for this type of provider within Montana on the Resource-Based Relative Value Scale (RBRVS), which is described later in this section. New West Health Services and our out-of-state provider network contractually agree to the fee schedule for this type of provider outside of Montana. If the plan has a point-of-service rider, the allowed charge for a health care professional who is a non-participating provider, whether inside or outside of Montana, is the allowed charge for that covered service when provided by a participating provider in Montana, less any adjustment set forth in the point-of-service rider.

The allowed charge for covered durable medical equipment and for covered services provided by laboratories, urgent care facilities, and ambulatory surgery centers also is determined by a fee schedule based on the RBRVS.

The allowed charge for a covered service provided by an institutional participating provider is determined by a fee schedule or a discount from billed charges that is a part of that provider's participation agreement. Institutions are hospitals, skilled nursing facilities, chemical dependency centers, and other facility providers. The methodology used to develop fee schedules for institutional participating providers varies by facility. The allowed charge for a covered service provided by an institutional non-participating provider is determined by the nature of the covered services provided, the facility type and market data.

The general methods for determining allowed charges for covered services may not apply in all circumstances. New West Health Services may negotiate payment arrangements on a provider-by-provider or case-by-case basis.

In any circumstance in which a provider's billed charges are less than the allowed charges for the covered services provided (after adjustment for special circumstances, as described previously), New West Health Services will pay the provider the provider's billed charges.

New West plan allowances are accepted by all participating providers as payment in full.

Us/We Us and We refer to New West Health Services.

You You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

See www.opm.gov/insure/health for enrollment information as well as:

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

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends; 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 benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status.

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.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal 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 Benefits 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 at 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 information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

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

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

Dependent Care FSA (DCFSA)– Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

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

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

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

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class D (Orthodontic) services with up to a 24-month waiting period.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Summary of benefits for New West Health Services - 2009

- 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.
- Below, an asterisk (*) means the item is subject to the $250 per person ($500 per family) calendar year deductible.

Benefits	You pay (In-Network)	Page
Medical services provided by physicians:		16
Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $15 specialist Procedures, lab and x-ray*	16
Services provided by a hospital:		32
• Inpatient	$100 per admission copay	32
• Outpatient	$100 per admission copay	33
Emergency benefits:		36
• In-area	$75 per emergency room visit	37
• Out-of-area	$75 per emergency room visit	37
Mental health and substance abuse treatment:	Regular cost sharing	38
Prescription drugs:		40
• Retail pharmacy	$10 generic, $20 brand, $40 brand non-formulary	41
• Mail order	2 copayments for 90-day supply	41
Dental Care:	No benefit.	42
Special features:	Out of State Benefits, Centers of Excellence, Travel Benefit	43
Point of Services benefits:	$500 self only/$1000 family deductible 30% coinsurance up to the $2,000 self only /$4,000 out-of-pocket maximum	44
Vision care:	In-Network benefit $10 exam and $100 allowance for hardware	46
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $1,500 self only/$3,000 family.	13

2009 Rate Information for New West Health Services -

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the Guide to Federal Benefits 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 Guide to Benefits *for Career* UnitedStates Postal Service Employees, RI 70-2, and to the rates shown below.

The rates shown below do not apply to *Post*al Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 Guide to Federal Benefits.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	NV1	$155.66	$73.84	$337.26	$159.99	$179.45	$50.05
High Option Self and Family	NV2	$352.56	$137.68	$763.88	$298.31	$406.42	$83.82