

Welborn Health Plans

<http://www.welbornhealthplans.com>



2009

A Health Maintenance Organization

Serving our ten county service area which includes Vanderburgh, Warrick, Posey, Gibson, Knox, Dubois, Pike, Spencer, Daviess and Perry Counties.

Enrollment in this plan is limited. You must live or work within our ten county service area to be covered under this plan.

Enrollment code for this Plan:

W1 1 Welborn Health Plans HMO – Self Only

W1 2 Welborn Health Plans HMO – 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 73-858

Important Notice from Welborn Health Plans About Our Prescription Drug Coverage and Medicare

OPM has determined that the Welborn Health Plans 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 under our contract (CS 2919) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Welborn Health Plans' administrative offices is:

Welborn Health Plans
101 S.E. Third Street
Evansville, Indiana 47708

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. Benefits are effective January 1, 2009. 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.
- 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 fehwebcomments@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 for your health care providers, 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 800-521-0265 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, DC 20415-1100**

- 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 Welborn Health Plans High Option

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. We offer you enrollment in an HMO Plan.

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 of our HMO Option

Approved Referral Process

Our HMO is based upon an Approved Referral Process. Our HMO defines an Approved Referral Process as a communication (oral, written or electronic) sent by a PCP to the Specialist that the Member is being referred to by that particular PCP.

How we pay providers

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

Preventive care services

Preventive care services are generally paid as first dollar coverage after a copayment.

Health education resources and accounts management tools

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.

- Years in existence
- Profit status

If you want more information about us, call 812-426-6600, or write to Welborn Health Plans, 101 S.E. Third Street, Evansville, Indiana 47708. You may also contact us by fax at 812-773-0589 or visit our Web site at welbornhealthplans.com.

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.

Service Area

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

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

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

Section 2. We are a new plan

- This Plan is new to the FEHB Program. We are being offered for the first time during the 2009 Open Season.

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 letter (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 812-426-6600 or write to us at Welborn Health Plans, 101 S.E. Third Street, Evansville, Indiana 47708. You may also request replacement cards through our Web site: www.welbornhealthplans.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, 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. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **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 will provide most of your health care, or give you a referral to see a specialist.

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**

Your primary care physician will refer you to a specialist for needed care. You may self refer to an OB/GYN or Mental Health provider. Emergency services may be provided without a referral.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else with prior authorization.
- 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 will need to complete a transition of care form and submit to WHP to be reviewed by our Medical Director for approval to continue to see the specialist. These decisions are made within two (2) business days provided we have all medical documentation required. Prior Authorizations for pregnancy are done upon the first prenatal visit by your physician.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements. Depending upon our contract arrangement with your plan primary care physician or specialist, it is possible for them or a hospitalist to supervise your case. 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 812-426-6600. 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** Participating hospitals are responsible for obtaining approval.
- **How to precertify an admission** Participating providers are responsible for precertification.
- **Maternity care** Participating providers are responsible for precertification.
- **What happens when you do not follow the precertification rules when using non-network facilities** Non-emergency care at non-network facilities requires precertification. If precertification is not obtained, you may be held responsible for all or part of the cost.

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.

Participating providers are responsible for precertification.

Section 4. Your cost for covered services

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

Copayments

A fixed dollar amount that must be paid by a member to a provider for covered services. Required copayment amounts are shown in your Benefit Summary.

Example: When you see your primary care physician you pay a copayment of \$20 per office visit and when you go in the hospital, you pay 10% coinsurance per admission.

Cost-sharing

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

Deductible

We do not have a deductible.

Coinsurance

The percent of eligible charges that the member must pay to a provider. Required coinsurance amounts are shown in your Benefit Summary.

Your catastrophic protection out-of-pocket maximum

This plan has an out-of-pocket maximum of \$1,000 per person; \$2,000 per family (copays do not apply to out-of-pocket maximum).

Carryover

This plan does not have a deductible.

Welborn Health Plans High Option Benefits

We are a new plan offering for 2009. Make sure that you review the benefits that are available.

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Summary of benefits for the Welborn Health Plans Option of the - 2009 65

Section 5. Welborn Health Plans High Option Benefits Overview

This Plan offers an HMO Option. The benefits are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about our HMO benefits, contact us at 800-521-0265 or at our Web site at www.welbornhealthplans.com.

Each option offers unique features.

- **Welborn Health Plans High Option**

Please refer to the Benefit Summary for a statement of the essential features of the Plan's coverage.

- **Unique Features of Welborn Health Plans High Option**

- No deductible
- Office visits to PCP, PA, NP or Specialist are only \$20 per office visit
- Labs, x-rays and other diagnostic services done in a physician's office are covered at 100%
- Chiropractic services (maximum benefit per contract year \$750) are \$20 per office visit
- Prescription Drug Coverage for a 90-day supply for 2-month copay. 90-day supply can be obtained through mail order and at retail! (except for antibiotics and controlled substances)

**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.
- 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
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$20 per office visit
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion 	\$35 per office visit (if there are no facility charges) 10% coinsurance per hospital stay 10% coinsurance per facility stay \$20 per office visit \$20 per office visit
Not covered: <i>At home</i>	All charges

Lab, X-ray and other diagnostic tests	You pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	<p>Nothing (if there are no facility charges)</p>
Preventive care, adult	You pay
<p>Routine physical one (1) every 12 months which includes: Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – 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 	<p>\$20 per office visit</p> <p>10% coinsurance</p>
<p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p>	<p>\$20 per office visit</p>
<p>Routine Pap test</p> <p>Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i>, above.</p>	<p>\$20 per office visit</p>
<p>Routine mammogram</p> <ul style="list-style-type: none"> • one mammogram every 12 months 	<p>10% coinsurance</p>
<ul style="list-style-type: none"> • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) 	<p>\$20 per office visit</p>
<p><i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<p>All charges</p>

Preventive care, children	You pay
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	\$20 per office visit
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 18) Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction, which include: Hearing exams through age 18 to determine the need for hearing correction, which include: Examinations done on the day of immunizations (up to age 18) 	\$20 per office visit All charges unless there is a vision rider or approved medical condition \$20 per office visit \$20 per office visit
Maternity care	You pay
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care Routine sonograms covered to determine age or size. 	\$20 per office visit 10% coinsurance for outpatient facility
Note: Here are some things to keep in mind: <ul style="list-style-type: none"> You do not need to precertify your normal delivery. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. 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). Case manager at the hospital will need to precertify the inpatient stay. 	10% coinsurance 10% coinsurance
<i>Not covered: Routine sonograms to determine fetal sex.</i>	All charges
Family planning	You pay
A range of voluntary family planning services, limited to: <ul style="list-style-type: none"> Voluntary sterilization (See Surgical procedures Section 5 (b)) 	Nothing

<ul style="list-style-type: none"> • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) [Drug covered under Prescription Drug Benefit; no charge for actual injection.] • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$20 per office visit</p> <p>Prescription copays apply for drug – no charge for actual injection.</p> <p>\$20 per office visit</p> <p>\$20 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<p>All charges</p>

Infertility services	You pay
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	<p>50% coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg.</i> 	<p>All charges</p>
Allergy care	You pay
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$20 per office visit</p> <p>\$5 per visit per injection</p>
<p>Allergy serum</p>	<p>Nothing</p>

Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 29.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) [Covered under the Prescription Drug Benefit.] 	10% coinsurance
Physical and occupational therapies	You pay
<p>Unlimited visits for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Members have coverage for no less than two (2) consecutive months per condition. Rehabilitation therapy services must be authorized by the medical director and be expected to result in marked improvement within sixty (60) days of starting therapy.</p> <p>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.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 24 sessions.</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs • Aqua therapy • Exercise equipment and exercise programs including equipment of a medical nature designed to exercise paralyzed muscles using electrical stimulation and/or passive motion 	10% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs • Aqua therapy • Exercise equipment and exercise programs including equipment of a medical nature designed to exercise paralyzed muscles using electrical stimulation and/or passive motion 	All charges
Speech therapy	You pay
<p>No visit limitation – members have coverage no less than two (2) months consecutive per condition.</p> <p>Rehabilitation therapy services must be authorized by medical director and be expected to result in marked improvement within sixty (60) days of starting therapy.</p>	\$10% coinsurance

Hearing services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 18, which include; (see <i>Preventive care, children</i>) • For coverage of hearing aids, hearing loss must be at least 40db in the most affected ear and hearing loss must have been diagnosed prior to child’s fifth birthday. Coverage limited to \$1,400 per ear. Replacement of hearing aids every 3 years when medically necessary. These individuals will be covered until their 18th birthday if still under this certificate. The \$1,400 per ear limit also applies to replacement. 	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> 	All charges
Vision services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> • Medical eye conditions such as diabetes and cataracts are covered when using WHP provider. • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) <p><i>Note: See Preventive care, children for eye exams for children.</i></p>	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, except as shown above</i> • <i>Annual eye refractions</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	All charges
Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Trimming of toenails is covered when a severe disease could cause damage to the feet. Examples include diabetes, vascular disease, peripheral neuropathy and other qualifying diseases as defined by the medical director.</p>	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>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)</i> 	All charges

<ul style="list-style-type: none"> • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. • Replacement covered only if member outgrows equipment. Replacement or repair after 4 years of use may be considered by WHP if due to normal wear and tear. Disposable or consumable bandages or medical equipment and/or supplies (including, but not limited to, sterile disposable supplies, needles and syringes) are excluded unless provided as a part of a skilled nursing visit. Please note: needles and syringes may be covered under a valid rider. Lancets and test strips used with glucometer are covered when received from a participating provider. <p>Note: Call us at 800-521-0265 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>20% coinsurance</p>
Home health services	You pay
<ul style="list-style-type: none"> • 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. <p>Note: Some medications may apply to Prescription copays.</p>	<p>10% coinsurance</p> <p>20% coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>Equipment provided mainly for the convenience of the patient or his family or for an adaptation to the home environment.</i> 	<p>All charges</p>
Chiropractic	You pay
<ul style="list-style-type: none"> • Manipulation of the spine and extremities (with a limit of \$750 per contract year) • Adjunctive procedures such as ultrasound, electrical muscle stimulation 	<p>\$20 per office visit</p>
<p><i>Not covered: Cold pack applications and vibratory therapy</i></p>	<p>All charges</p>

Alternative treatments	You pay
<ul style="list-style-type: none"> • Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief and covered only in conjunction with our Finally Beat Smoking Program. • Hypnotherapy, covered only in conjunction with our Finally Beat Smoking Program. • Biofeedback, requires review by medical director to determine medical necessity 	<p>\$20 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> 	<p>All charges</p>
Educational classes and programs	You pay
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking cessation (We provide free educational information through our Finally Beat Smoking Program.) • Diabetes self management 	<p>\$20 per office visit; outpatient facility 10% coinsurance</p>

Surgical procedures <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns <p>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.</p>	<p>\$20 per office visit or 10% coinsurance</p> <p>\$20 per office visit or 10% coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p>All charges</p>
Reconstructive surgery	You pay
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – 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: <ul style="list-style-type: none"> – Breast reconstruction following a masectomy as dictated by the women’s health and cancer rights act of 1998. – surgery to produce a symmetrical appearance of breasts; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>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. Reconstructive services provided while a member of WHP are covered for one (1) year from the date of original injury/disease. For children or for breast reconstruction, the one (1) year time limit does not apply. Reconstructive services do not include penile prosthesis.</p>	<p>\$20 per office visit or 10% coinsurance</p>

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sex transformation</i> 	<p>All charges</p>
<p>Oral and maxillofacial surgery</p>	<p>You pay</p>
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip or cleft palate; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and <p>Other surgical procedures that do not involve the teeth or their supporting structures.</p>	<p>10% coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Severe functional malocclusion</i> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p>All charges</p>
<p>Organ/tissue transplants</p>	<p>You pay</p>
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <ul style="list-style-type: none"> – Small intestine 	<p>10% coinsurance</p>

Note: Transportation and lodging expenses for the Member/Family covered up to \$10,000 maximum. Medical Director approval is required prior to receiving transplant services.

Organ/tissue transplants (continued)	You pay
<ul style="list-style-type: none"> - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	10% coinsurance
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Neuroblastoma - <u>Amyloidosis</u> • Autologous tandem transplants for <ul style="list-style-type: none"> - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - De-novo myeloma 	10% coinsurance
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic/<u>Hemophagocytic</u> deficiency diseases (e.g., Wiskott-Aldrich syndrome) 	10% coinsurance

Organ/tissue transplants – continued on next page.

Organ/tissue transplants (continued)	You pay
<ul style="list-style-type: none"> – Advanced neuroblastoma – Infantile malignant osteopetrosis – Kostmann’s syndrome – Leukocyte adhesion deficiencies – Mucopolidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) – Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) – Myeloproliferative disorders – Sickle cell anemia – X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> – Multiple myeloma – Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors – Breast cancer – Epithelial ovarian cancer – Ependyoblastoma – Ewing’s sarcoma – Medulloblastoma – Pineoblastoma – Waldenstrom’s macroglobulinemia 	10% coinsurance
Mini-transplants (non-myeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity.	10% coinsurance
Tandem transplants for covered transplants: Subject to medical necessity.	10% coinsurance

Organ/tissue transplants (continued)	You pay
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> – Chronic lymphocytic leukemia – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – Early stage (indolent or non-advanced) small cell lymphocytic lymphoma – Myelodysplasia/Myelodysplastic syndromes – Multiple myeloma – Multiple sclerosis • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Myelodysplasia/myelodysplastic syndromes – Advanced Hodgkin’s lymphoma – Advanced non-Hodgkin’s lymphoma – Breast cancer – Chronic lymphocytic leukemia – Chronic myelogenous leukemia – Colon cancer – Early stage (indolent or non-advanced) small cell lymphocytic lymphoma – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – Multiple myeloma – Multiple sclerosis – Myeloproliferative disorders – Non-small cell lung cancer – Ovarian cancer – Prostate cancer 	<p>10% coinsurance</p>

Organ/tissue transplants (<i>continued</i>)	You pay
<ul style="list-style-type: none"> – Renal cell carcinoma – Sarcomas • Autologous transplants for <ul style="list-style-type: none"> – Chronic lymphocytic leukemia – Chronic myelogenous leukemia – Early stage (indolent or non-advanced) small cell lymphocytic lymphoma – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – Small cell lung cancer – Multiple sclerosis – Systemic lupus erythematosus – Systemic sclerosis – Scleroderma-SSc (severe, progressive) • National Transplant Program (NTP) - <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient as long as recipient is WHP member.</p>	10% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	All charges
Anesthesia	You pay
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	10% coinsurance
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	10% coinsurance 10% coinsurance 10% coinsurance \$20 per office visit

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.
- 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
Inpatient hospital	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • 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 • 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.) 	<p>10% coinsurance</p>

Inpatient hospital (continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as schools • Private duty nursing 	All charges
Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • 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 <p>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. Hospital care related to Dental Services, including anesthesia services, for Dependent children under the age of nineteen (19) or Dependents with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual.</p> <p>Dental services needed for the treatment or repair of damage because of trauma to sound natural teeth. Treatment must be performed within twelve (12) months of injury. Replacement of teeth with artificial teeth, dental prosthesis or dental implants are not Covered</p>	10% coinsurance
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	All charges
Extended care benefits/Skilled nursing care facility benefits	You pay
<p>Extended care benefit:</p>	10% coinsurance
<p>Skilled nursing facility (SNF) (maximum benefit per condition: 100 days):</p>	10% coinsurance
<p><i>Not covered: Custodial care</i></p>	All charges

Hospice care	You pay
Services provided to or for the benefit of a Member diagnosed by a Physician as terminally ill with a prognosis of six (6) months or less to live. The term also includes services given in agreement with Medicare-certified programs, under the direction of a Physician.	10% coinsurance
<i>Not covered: Independent nursing, homemaker services</i>	All charges
Ambulance	You pay
Local professional ambulance service when medically appropriate	Ground - \$50 copay per trip. Air/water - \$250 copay per trip then 10% coinsurance.

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.
- 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: Go to the nearest emergency room

Emergencies within our service area Any life-threatening emergencies, go to nearest hospital.

Emergencies outside our service area Services covered in-network for true emergencies.

Please refer to the guidelines below when assessing a medical emergency:

Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably be expected to result in:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part; or

With respect to a pregnant woman who is having contractions:

1. A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or
 2. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.
-

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • 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 <p>(A Member goes to a Hospital emergency room and is admitted directly to the Hospital as an inpatient, the emergency room Copayment is waived. The Member must contact his PCP within forty-eight (48) hours or as soon as reasonably possible. This allows the PCP to be informed of the Member’s condition and the PCP can coordinate his care. (NOTE: If the Member is a minor, his parent or guardian must contact the PCP.)</p> <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$20 per visit</p> <p>\$35 per visit</p> <p>\$75 per visit (waived if admitted); 10% coinsurance for physician fees</p>
<i>Not covered: Elective care or non-emergency care</i>	All charges

Emergency outside our service area	You pay
<ul style="list-style-type: none"> • 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 <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$20 per office visit</p> <p>\$35 per office visit</p> <p>\$75 per visit (waived if admitted); 10% coinsurance for physician fees</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	All charges

Accidental injury	You pay
	\$75 per visit; 10% coinsurance facility
Ambulance	You pay
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>Ground - \$50 copay per trip. Air/water - \$250 copay per trip then 10% coinsurance</p>

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.
- 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
Mental health and substance abuse benefits	
<p>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.</p> <p>Maximum Chemical Dependency Benefit per contract year is 14 inpatient days and 20 office visits.</p> <p>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.</p>	<p>10% coinsurance</p> <p>\$20 per visit</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$20 per visit</p> <p>Prescription drug copays apply</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing in physician office. If physician is seen, the copays may apply.</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>10% coinsurance</p> <p>10% coinsurance</p>
<p><i>Not covered: Services we have not approved.</i></p> <ul style="list-style-type: none"> • <i>Half-way house</i> <p><i>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.</i></p>	<p>All charges</p>

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

For instructions on network entry procedures, network restrictions, how to identify providers and obtain provider directories, inpatient and outpatient service and treatment plan approvals, please call Member Services at 800-521-0265.

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.
- 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.** Any participating provider may write your prescription if permitted to do so under state licensing laws.
- **Where you can obtain them.** You may obtain prescriptions at any participating pharmacy nationwide. In an emergency, a non-participating pharmacy may be used.
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan doctor.
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 800-521-0265 or visit www.welbornhealthplans.com.
- **These are the dispensing limitations.** Antibiotics and controlled substances are limited to no more than a 30-day supply. Maintenance medications may be obtained at a participating pharmacy for up to a 90-day supply for two copayments. For a complete list of limited medications, please refer to our formulary list located at www.welbornhealthplans.com.
- **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?** A generic drug is therapeutically equivalent (contains the same active ingredient(s), is the same strength and the same dosage form to a brand name drug. It is referred to by its chemical name, and is generally made available when patent protection on the brand name drug expires. Generics account for more than 45% of all medications prescribed in the U.S. More people are choosing generic drugs because they are: 1) **Safe** – They have the same active ingredients and are used in the body the same way as their original brand-name drugs. They are also approved by the U.S. Food and Drug Administration (FDA), just like brand-name drugs. 2) **Effective**- They are just as strong and deliver the same medical benefits as brand-name drugs. 3) **Less Expensive** – Members can generally save 30%-60% out-of-pocket expenses by switching to generics. 4) **Available** – More and more generic drugs are becoming available in the next 5 years as the patents of their equivalent brand products (e.g., Zocor, Zolof, and Ambien) expire. To take advantage of huge saving opportunities, we recommend you discuss the generic drug therapy and availability with your pharmacist or physician; request a generic equivalent using existing refills of the brand medication; and should you run out of refills, contact your physician to request a new generic equivalent prescription. To learn more about generic products, visit the FDA Center for Drug Evaluation and Research, Office of generic Drugs website at www.fda.gov/cder/ogd/index.htm.
- **When you do have to file a claim.** If you obtain a prescription at a non-participating pharmacy and pay the cost yourself, you may submit the receipt to: MedImpact, 106 Treena Street, 5th Floor, San Diego, California 92131.

Prescription drugs (continued)	
Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Diabetic supplies limited to • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Contraceptive drugs and devices <p>Please refer to our formulary list which includes quantity limitations and drugs which require prior authorization located on our website at www.welbornhealthplans.com.</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>	<p>At a participating retail pharmacy for a 30-day supply per prescription unit or refill:</p> <p>\$10 copay for generic drugs</p> <p>\$25 copay for preferred brand name drugs</p> <p>\$40 copay for non-preferred brand name drugs</p> <p>From the mail service pharmacy for up to a 90-day supply per prescription or refill:</p> <p>\$20 copay for generic drugs</p> <p>\$50 copay for preferred brand name drugs</p> <p>\$80 copay for non-preferred brand name drugs</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> 	<p>All charges</p>

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
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- 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
<p>We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.</p> <p>Dental services needed for the treatment or repair of damage because of trauma to sound natural teeth. Treatment must be performed within twelve (12) months of injury. Replacement of teeth with artificial teeth, dental prosthesis or dental implants are not Covered.</p> <p>Hospital care related to Dental Services, including anesthesia services, for Dependent children under the age of nineteen (19) or Dependents with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual.</p> <p>Anesthesia and hospital or facility charges are Covered for dental services performed in a hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine (9) years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the dentist treating the patient or admitting physician involved certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.</p>	<p>10% coinsurance</p>

Dental benefits	You pay
<p>We have no other dental benefits.</p>	<p>All charges</p>

Section 5(h). Special features

Feature	Description
WHP Navigator Hot Line	For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions. These services provided through our WHP Navigator program at 866-407-9214.
Services for deaf and hearing impaired	Call 800-743-3333
Finally Beat Smoking Program	Provides support and the opportunity to talk with a nurse regarding any help to become smoke free! Call 800-521-0265.

Section 6. General exclusions – things we do not 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** (see specifics regarding transplants).

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/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; 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 800-521-0265.

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: Welborn Health Plans, 101 S.E. Third Street, Evansville, Indiana 47708.

Prescription drugs

Submit your claims to: MedImpact, 106 Treena Street, 5th Floor, San Diego, California 92131.

Other supplies or services

Submit your claims to: Welborn Health Plans, 101 S.E. Third Street, Evansville, Indiana 47708.

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. Member is given forty-five (45) days extension to submit if additional information is requested.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at Welborn Health Plans, 101 S.E. Third Street, Evansville, Indiana 47708; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk 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	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>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.</p>

The disputed claims process (*continued*)

Send OPM the following information:

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

Note: If you want OPM to review 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 preauthorization/prior approval, then call us at 800-521-0265 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 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. This is called “double coverage.”

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

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

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

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age 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 three Medicare Advantage Plans: the WHP Silver (medical only), WHP Silver Rx (medical and Rx); and WHP Platinum (enhanced medical and Rx). 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. TTY users may call 800-325-0778 or visit www.ssa.gov.

• 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 800-325-0778 or see our website at www.ssa.gov.

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:

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. This plan would be primary.

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

WHP provides benefits for care, treatment, supplies, and equipment for an illness, injury, or condition that is job-related, only if the Member is not required to be enrolled in Indiana's Worker's Compensation (or a similar state or federal program), and provided such care, treatment, supplies and equipment is or are otherwise Covered under this Agreement. If the Member is covered by Worker's Compensation, and the Member files a claim with WHP that WHP determines is for a work-related illness, injury or condition, the claim will be denied by WHP and the Member is required to file a claim with Worker's Compensation. If Worker's Compensation denies the claim as not being work-related, WHP will pay benefits under this Agreement, if benefits would otherwise be Covered under this Agreement. If WHP, in its sole judgment determines, following the initial denial of the claim by Worker's Compensation, that notwithstanding the denial, the claim is work-related, the Member is required to appeal the initial denial of the claim by Worker's Compensation. If Worker's Compensation pays the claim upon appeal, WHP has the right to reimbursement for the payments WHP made.

It is the Member's responsibility to file claims, fill out forms and provide all necessary information and cooperation required to secure Worker's Compensation benefits. It is the Member's responsibility to file an appeal of the initial Worker's Compensation. WHP benefits will not be paid if the Member is required to be covered by Worker's Compensation but is not, chooses not to file a claim with Worker's Compensation or fails to appeal an initial denial by Worker's Compensation. If WHP has paid a claim that in WHP's sole discretion is for a work-related illness, injury, or condition, and the Member does not file a claim with Worker's Compensation or appeal an initial denial by Worker's Compensation, the Member will be liable to WHP for the payments made by WHP towards the claim. If a Member receives an award from Worker's Compensation or agrees to settle a claim for permanent total or partial disability for a claim that can be settled under Worker's Compensation, the Member is responsible to pay for future medical and diagnostic services and medical equipment for or relating to the injury or condition that caused the disability

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

General. If a Member or Dependent's injury or illness is caused by the acts or omissions of another party and WHP has paid expenses for such injury or illness, WHP will have the right to be reimbursed if the Member receives any payment from the other party. WHP is subrogated to all of the Member's rights against any party legally liable to pay for the Member's injury or illness. This right includes but is not limited to liability insurers of the other person and insurers covering the Member through: uninsured automobile coverage, under-insured automobile coverage, medical pay coverage under homeowner's insurance and automobile insurance policies, medical benefits coverage of an Employer, Employer-type and individual

“no-fault” and traditional automobile “fault” agreements, and workers compensation recoveries. WHP may declare this right independently of the Member.

Expenses. When used in this section the term Expenses means the costs of all medical, surgical and hospital care furnished to the Member and provided, arranged or paid by WHP, figured on the basis of the usual, customary and reasonable fees charged by health care providers of such services. When medical expenses acquired by WHP have been subject to contractual discounts or capitation agreements, WHP shall be entitled to reimbursement based on the usual and customary fees charged by health care providers of such services, without regard to contractual discounts or capitation agreements.

Cooperation. The Member or anyone acting legally on his behalf must:

- a. Fully cooperate with WHP in order to protect WHP’s subrogation rights.
- b. Give notice of WHP’s claim to third parties and their insurers who may be legally responsible.
- c. Provide WHP with relevant information, sign, and deliver such documents as WHP reasonably requests to secure WHP’s subrogation claims.
- d. Obtain WHP’s consent before releasing any party from liability for medical expenses or services paid or provided.

If the Member enters into litigation or settlement negotiations regarding the obligations of other parties, the Member must not prejudice, in any way, WHP’s subrogation rights.

Reimbursement of WHP.

When Member receives payment from a third party, Member agrees to hold those funds received in trust for WHP. The Member will pay WHP from any funds received from another party by settlement, judgment, or otherwise, up to the amount of benefits provided by WHP in connection with the loss. Where there is a judgment in favor of the Member and the amount of the recovery is reduced due to fault on the part of the Member, there will be a pro-rata reduction in the amount WHP is to be paid. In such event, the amount WHP is to be paid will equal:

- a. The total benefits provided by WHP for the loss.
- b. The total benefits provided by WHP for the loss multiplied by the percent that the Member’s recovery was reduced due to the Member’s fault.

WHP shall have a lien on all funds the Member receives in connection with the loss. This will be in the amount of the benefits given by WHP to the Member.

WHP may give notice of its lien to any person or organization that is legally responsible for the loss and/or any person or organization that may be required to make payment to or for the Member in connection with the loss.

WHP may sue a third-party on behalf of the Member.

Section 10. Definitions of terms we use in this brochure

Approved Referral	A communication (oral, written, or electronic) sent by a PCP or other Participating Provider that specifies the health services to be rendered by another Provider identified in such communication and approved by the WHP Health Services Department (HSD) or WHP Medical Director. This approval is not a guarantee that WHP will Cover the requested health service or item because of other provisions in this Agreement. Exhibits, Eligibility, Exclusions, Limitations, Coordination of Benefits, the Benefit Summary and any applicable Riders also control whether a requested health service or item will be Covered by WHP.
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	The percent of Eligible Charges that the Member must pay to a Provider. Required Coinsurance amounts are shown in your Benefit Summary . You may also be responsible for additional amounts.
Copayment	A fixed dollar amount that must be paid by a Member to a Provider for Covered Services. Required Copayment amounts are shown in your Benefit Summary.
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	The services arranged for, paid for by WHP and for which benefits apply..
Custodial care	Care in an inpatient or outpatient setting to protect or maintain a stable level of functioning in a patient whose general condition and physical findings remain substantially constant, and for which, in the opinion of the Medical Director, no improvement is expected. Such care is Custodial even if the level of maintenance care requires services of some skilled health professionals.
Dental Services	Professional services for the diagnosis and treatment of disease or defects of, or accidental injury to, the teeth, gums, jaws and associated structures. Dental Services include dental examination and consultations, oral surgery and hospitalization for dental-related care.
Durable Medical Equipment (DME)	Products that are required for treatment, rehabilitation of, or compensation for medical disability that are primarily medical, non-disposable, and intended for repeated use.
Eligible Charge	The amount of money WHP allows for Covered services. This amount includes what both WHP and the Member are to pay.
Emergency Medical Condition	<p>A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably be expected to result in:</p> <ol style="list-style-type: none">1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;2. Serious impairment to bodily functions; or3. Serious dysfunction of any bodily organ or part; or <p>With respect to a pregnant woman who is having contractions:</p> <ol style="list-style-type: none">1. A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or <p>A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.</p>

Experimental or investigational services

A health care service is Experimental/Investigative if WHP's Medical Management staff determines:

- a. It is a drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration ("FDA") and FDA approval has not been given at the time the drug or device is proposed to be used; or
- b. It is a drug, device, medical treatment, or procedure, for which:
 - i. 21 C.F.R. §50.20 and/or 45 C.F.R. §46.116 require(s) that a patient informed consent document be used; and
 - ii. Federal law requires the review and approval of such drug, device, medical treatment or procedure by the treating facility's Institutional Review Board or other body serving a similar function; or
- c. It is a drug, device, medical treatment or procedure that reliable evidence shows:
 - i. Is the subject of on-going phase I, phase II or phase III clinical trials;
 - ii. Is under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared with a standard means of treatment or diagnosis; or
- d. It is a drug, device, medical treatment or procedure needing further studies as shown by reliable evidence that establishes that the current prevailing opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness or its effectiveness as compared with the standard means of treatment or diagnosis; or
- e. With regard to treatment of the Member's diagnosed condition, disease or injury, reliable evidence has not established the effectiveness of the proposed medical treatment or procedure or the proposed use of the drug or device for that particular condition, disease or injury.

Reliable evidence is published reports and articles in authoritative medical and scientific literature or written protocol(s) or the written informed consent used by the treating facility or another facility studying substantially the same drug, device, medical treatment or procedure.

Group health plan

An employee welfare benefit plan [as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. 1002(1)], including insured and self-insured plans, to the extent that the plan provides medical care [as defined in section 791 (a)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 300gg-91(a)(2)], including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

- a. Has fifty (50) or more participants [as defined in section 3(7) of ERISA, 29 U.S.C.1002(7)]; or
- b. Is administered by an entity other than the Employer that established and maintains the plan.

Home Health Care

Health Care services given in the home that are Medically Necessary and not Custodial in nature. A licensed Health Care Professional who is not related to the Member receiving care shall provide these services. These services shall include, but are not limited to, skilled nursing visits, physical therapy, speech therapy, and/or occupational therapy.

Hospice Care

Services provided to or for the benefit of a Member diagnosed by a Physician as terminally ill with a prognosis of six (6) months or less to live. The term also includes services given in agreement with Medicare-certified programs, under the direction of a Physician.

Hospital

An institution:

- a. Constituted, licensed and run according to the laws of the state in which it is located.
- b. Has the inpatient facilities needed to diagnose and treat injury and sickness.
- c. Provides services under Medicare.

The term "Hospital" will not include an institution that is, other than incidentally, a nursing home or a Federal Hospital.

Medical Director	A Physician designated by WHP to direct its medical affairs.
Medical necessity	<p>A health care service or item that, in the judgment of the Medical Director or his designee:</p> <ol style="list-style-type: none"> 1. Is appropriate and consistent with the diagnosis and that could not have been omitted without harming the patient's condition or the quality of health services received, as in agreement with accepted medical standards in the WHP Service Area. 2. Is required for reasons other than (i) the convenience of the Member or his Physician or (ii) solely for Custodial Care, comfort, convenience, appearance, educational, recreational, vocational or maintenance reasons. 3. Is performed in the most appropriate manner in terms of treatment method, setting, frequency and intensity, taking into consideration the Member's medical condition and type of setting appropriate for the condition. 4. As to inpatient care or institutional care, could not have been provided in a Physician's office, the outpatient department of a Hospital or a non-residential facility without harming the patient's condition or quality of health services received. 5. Is not excluded by Medicare Guidelines
Members	A Subscriber or Eligible Dependent for whom WHP has agreed to provide health care services pursuant to this Agreement.
Non-Participating	A person or institution that does not have a contract or arrangement with WHP to provide Covered Services to Members.
Orthotic	Biomechanical devices used to correct diseases or disorders of locomotion.
Out-of-Area	A location outside of the WHP Service Area. The Subscriber must live or work in the Service Area to be eligible for coverage under this Agreement unless Covered under the Point-Of-Service ~ SELECT Rider. Please refer to Section 19 of this Agreement for a listing of counties included in the Service Area.
Out-of-Plan	Covered Services that are not provided by a Member's PCP or obtained by an approved referral from the Member's PCP. For example, seeking care from a Physician who is not a Participating Provider for non-Emergency conditions is Out-Of-Plan. Out-Of-Plan services will not be Covered or paid for unless (i) WHP gives advance authorization (Prior Authorization) to the Member to obtain such services or (ii) the services are Covered by a valid Point-Of-Service ~ SELECT Rider. If Out-Of-Plan services are Precertified by WHP, the Member is responsible for submitting claims to WHP within ninety (90) days and for paying any applicable Copayments, Coinsurance and Deductibles. A Member is responsible for paying all costs of obtaining Out-Of-Plan services that are not Precertified or Covered by a valid Point-Of-Service ~ SELECT Rider. Members Covered under a valid Point-Of-Service Rider ~ SELECT are responsible for applicable Copayments, Coinsurance and Deductibles and charges exceeding the allowed amount.
Out-of-Pocket Maximum	The maximum amount of money a Member has to pay during a calendar year for Eligible Charges for Covered Services.
Participate(s)(ing)	A Provider who is under contract with WHP to provide services to Members pursuant to this Agreement.
Physician	A person who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice medicine or osteopathic medicine in the state in which he practices.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

Prescription Drugs	Drugs or medications, the sale or dispensing of which, legally requires the order of a Physician or a Provider and that carry the Federally required product legend stipulation that such drug may not be dispensed without a prescription. Prescription Drugs must be dispensed by a Participating pharmacy.
Primary Care Physician (PCP)	A pediatrician, family practice Physician, or internal medicine Physician who is a Participating Provider. This Physician is selected by the Member and named by WHP to manage all of the Member's health needs.
Prior Authorization	This is the process for obtaining approval for a proposed health service. The requesting provider must submit complete clinical information justifying the medical necessity of a proposed treatment or service. Once a service is prior authorized, there is not a guarantee of payment since the Member must be eligible for benefits on the date of service the treatment is rendered.
Prosthetic	Devices that are prescribed to replace all or part of an absent body part or to replace all or part of the function of a permanently inoperable or malfunctioning body part.
Provider	A Health Care Professional, licensed health care institution (a Hospital, Skilled Nursing Facility, or Rehabilitation Facility), or a supplier.
Referral or Referred	A communication sent by a PCP or other Participating Provider (oral, written, or electronic) that specifies health services to be rendered by another Provider identified in such communication.
Rehabilitation Facility	A facility providing complex medical or behavioral treatment and skilled nursing services intended to restore an individual to a maximum level of functioning following a disabling disease or injury.
Rider	An optional benefit that the Member's Employer may elect to include as Covered Services under this Agreement.
Semi-Private	A room in a Hospital, Skilled Nursing Facility or any other inpatient facility containing two (2) or more beds and/or classified as Semi-Private by such facility.
Service Area	The counties and states where WHP provides or arranges for the health care services to WHP Members. The Subscriber must live or work in the Service Area to be eligible for coverage under this Agreement unless Covered under a valid Point-Of-Service ~ SELECT Rider. WHP's Service Area includes the counties listed in Section 19 of this Agreement. All other locations are outside the Service Area or "Out-of-Area."
Skilled Nursing Facility	A facility that: <ul style="list-style-type: none"> a. Is primarily engaged in providing skilled nursing care and related services on a twenty-four (24) hour a day basis to inpatients requiring medical or skilled nursing care. b. Is recognized and eligible to be paid under Medicare as a Skilled Nursing Facility.
Therapy Services	Services and supplies used to promote recovery from an illness or injury. These services shall include services provided by Physical, Occupational, and Speech Therapists in accordance with their scope of practice under state law. It shall also include organized programs of cardiac or pulmonary rehabilitation.
Urgent or Urgent Condition	An acute health problem that starts suddenly and is not expected. It is not a threat to life, but has a serious danger to health if not treated within twenty-four (24) hours. An Urgent Condition is one, in the opinion of a physician with knowledge of the Member's medical condition, which would subject the Member to severe pain that cannot be adequately managed without care or treatment. Examples of Urgent Conditions can be simple fractures, cuts needing stitches and serious infections.

Us/We

Us and We refer to the Plan.

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*, 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, divorcé, or when your child under age 22 marries.

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 Employees 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/dental/vision. 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 1-877-888-3337 (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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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the Welborn Health Plans HIGH Option - 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.

Welborn Health Plans HIGH Option	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$20 primary care; \$20 specialist	15
Services provided by a hospital:		
• Inpatient	Nothing	32
• Outpatient	Nothing	33
Emergency benefits:		
• In-area	\$75 per visit	37
• Out-of-area	\$75 per visit	37
Mental health and substance abuse treatment:	Regular cost sharing	39
Prescription drugs:		41
• Retail pharmacy	Level 1: \$10; Level 2: \$25; Level 3: \$40	
• Mail order (90-day supply)	Level 1: \$20; Level 2: \$50; Level 3: \$80	
Dental care:	No benefit.	43
Vision care:	No benefit.	
Special features:		44
Catastrophic Protection out-of-pocket maximum	This plan has an out-of-pocket maximum of \$1,000 per person; \$2,000 per family (copays do not apply to the out-of-pocket maximum).	11

2009 Rate Information for Welborn Health Plans HIGH Option

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 United States Postal Service Employees, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal 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	W11	\$155.66	\$85.92	\$337.26	\$188.16	\$179.45	\$62.13
High Option Self and Family	W12	\$352.56	\$212.74	\$763.88	\$460.94	\$406.42	\$158.88