

# New West Health Services

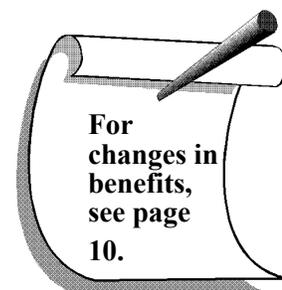
[www.newwesthealth.com](http://www.newwesthealth.com)



## 2011

## A Health Maintenance Organization and Point of Service Product

Serving: Anaconda, Big Timber, Big Sandy, Billings, Bozeman, Butte, Chester, Choteau, Columbus, Conrad, Cut Bank, Deer Lodge, Dillon, Ennis, Fallon, Forsyth, Fort Benton, Galata, Great Falls, Hamilton, Hardin, Harlowton, Havre, Helena, Inverness, Joplin, Jordan, Kalispell, Lewistown, Libby, Livingston, Malta, Mildred, Miles City, Missoula, Philipsburg, Plains, Plentywood, Polson, Red Lodge, Ronan, Roundup, Rudyard, Scobey, Shelby, Sheridan, Sidney, Superior, Terry, Townsend, Whitefish and White Sulphur Springs in Montana.



Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 9 for requirements.

Enrollment code for this Plan:

NV1 High Option - Self Only

NV2 High Option - Self and Family

NV4 Standard Option - Self Only

NV5 Standard Option - Self and Family

**Special Notice:** New West Health Services is offering a new Standard Option benefit along with the HighOption benefit for 2011.



Authorized for distribution by the:



United States  
Office of Personnel Management

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

RI 73-821

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

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

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

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

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**Please be advised**

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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](http://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](http://www.medicare.gov) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048)

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## Introduction

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

New West Health Services  
130 Neill Avenue  
Helena, MT 59601

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2011, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2011, and changes are summarized on page 10. Rates are shown at the end of this brochure.

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## Plain Language

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All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means New West Health Services.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at [www.opm.gov/insure](http://www.opm.gov/insure) or e-mail OPM at [fehbwebcomments@opm.gov](mailto:fehbwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Operations, Program Planning & Evaluation, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800-290-3657 and explain the situation.
  - If we do not resolve the issue:

**CALL - THE HEALTH CARE FRAUD HOTLINE**

**202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management**

**Office of the Inspector General Fraud Hotline**

**1900 E Street NW Room 6400**

**Washington, DC20415-1100**

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26).
- 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 if you are no longer enrolled in the Plan.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

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## **Preventing Medical Mistakes**

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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.

### **Patient Safety Links**

- [www.ahrq.gov/consumer/](http://www.ahrq.gov/consumer/) 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](http://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/](http://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](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.

- [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- [www.quic.gov/report/toc.htm](http://www.quic.gov/report/toc.htm) 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.

### **Never Events**

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Plan providers. This new policy will help protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that will encourage hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events." When a Never Event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

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## Section 1. Facts about this HMO Plan

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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 the most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

As a non-grandfathered health plan, this plan has also decided to follow the requirements that apply to grandfathered plans.

Questions regarding what protections apply may be directed to New West Health Services at **1-800-290-3657**. You can also read additional information from the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).

### **General features of our High and Standard Options**

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

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

- Orthopedic Appliances
- Outpatient Rehabilitative Therapy
- Oral Surgery

**We have Point of Service (POS) benefits (High Option only)**

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

**How we pay providers**

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your deductible, copayments or coinsurance. See Section 5 (i), Point of Service Benefits.

**Preventive Care Services**

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

**Annual deductible (High Option)**

The annual deductible must be met before Plan benefits are paid for care other than preventive services.

**Catastrophic Protection**

We protect you against catastrophic out-of-pocket expenses for covered services. For the High Option, your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$1,500 for self-only enrollment, or \$3,000 for family coverage. For the Standard Option, your annual out-of-pocket expenses for covered services, including copayments, cannot exceed \$5,000 for self-only or family coverage.

**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](http://www.opm.gov/insure)) lists the specific types of information that we must make available to you. Some of the required information is listed below.

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

If you want more information about us, call 1-800-290-3657, or write to Customer Services, New West Health Services, 130 Neill Avenue Helena, MT 59601. You may also contact us by fax at 406-457-2299 or visit our website at [www.newwesthealth.com](http://www.newwesthealth.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 and or work in our Service Area. This is where our providers practice. Our service area consists of the area within a 30 mile radius of the following Montana cities: **Anaconda, Big Timber, Big Sandy, Billings, Bozeman, Butte, Chester, Choteau, Columbus, Conrad, Cut Bank, Deer Lodge, Dillon, Ennis, Fallon, Forsyth, Fort Benton, Galata, Great Falls, Hamilton, Hardin, Harlowton, Havre, Helena, Inverness, Joplin, Jordan, Kalispell, Lewistown, Libby, Livingston, Malta, Mildred, Miles City, Missoula, Philipsburg, Plains, Plentywood, Polson, Red Lodge, Ronan, Roundup, Rudyard, Scobey, Sidney, Shelby, Sheridan, Superior, Terry, Townsend, Whitefish, and White Sulphur Springs in Montana.**

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. Other health care services out of our service area (unless the services have prior plan approval) will apply to the Point of Service benefit, at a reduced benefit.

If you or a covered family member moves outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan. However, if your dependents live out of the area, New West Health Services has an arrangement with a National Network of Providers. If you or a family member moves, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

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## Section 2. How we change for 2011

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

### **Program Wide Changes:**

- Several provisions of the Affordable Care Act (ACA) affect eligibility and benefits under the FEHB Program and FSAFEDS beginning January 1, 2011. For instance, children up to age 26 will be covered under a Self and Family enrollment. Please read the information in Sections 11 and 12 carefully.
- We have reorganized organ and tissue transplant benefit information to clarify coverage.
- We have reorganized mental health and substance abuse benefits to clarify coverage.

### **Changes to High Option:**

- Your share of the non-Postal premium will increase for Self Only or increase for Self Only and Family. See page 76.
- Benefits for alternative treatments including Naturopathic, Acupuncture, licensed massage therapy combined with the \$500 annual limit for Chiropractic services.
- Smoking cessation programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence have been added at no cost to the enrollee.
- Preventive care for adults and children will be \$0 cost to the enrollee. Previously, there was a \$15 copay.

### **Service Area Expansion:**

- New West Health Services has expanded the service area to include the following cities:
  - Cut Bank, Ennis, Scobey, and Sheridan

### **Changes to this Plan:**

- New West has added a **new** Standard Option for 2011. Please see Section 5 for a description of benefits.

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## Section 3. How you get care

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<b>Identification cards</b>	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times and show it to the provider whenever you receive services or fill a prescription. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>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 Customer Services at 800-290-3657 or write to us at 130 Neill Avenue, Helena, MT 59601. You may also request replacement cards through our Web site: <a href="http://www.newwesthealth.com">www.newwesthealth.com</a>.</p>
<b>Where you get covered care</b>	<p>You may access care from "Plan Providers" and "Plan Facilities." You are required to pay co-payments, coinsurance, and deductibles in accordance with your benefit plan. You may access care from providers that are not considered "Plan Providers" or "Plan Facilities" using your point-of-service benefit, however using non plan providers and facilities will cost you more. Please contact Customer Service at 800-290-3657 or visit <a href="http://www.newwesthealth.com">www.newwesthealth.com</a> for a current listing of plan providers and plan facilities.</p>
<ul style="list-style-type: none"><li>• <b>Plan providers</b></li></ul>	<p>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.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.</p>
<ul style="list-style-type: none"><li>• <b>Plan facilities</b></li></ul>	<p>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.</p>
<b>What you must do to get covered care</b>	<p>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.</p>
<ul style="list-style-type: none"><li>• <b>Primary care</b></li></ul>	<p>New West Health Services does not require you to choose a primary care physician, however, we strongly recommend that you do. A personal physician who knows you, your health care needs, and your personal preferences can guide you through a complicated system to get care you need. Your primary care physician can be a family practitioner, internist, or pediatrician. Your primary care physician will provide most of your health care. If you decide to choose a primary care physician, please let us know so we can, with your permission, alert you and your provider to recommended health care that may have been missed.</p>
<ul style="list-style-type: none"><li>• <b>Specialty care</b></li></ul>	<p>You may see any specialist within the New West Health Services Network without a referral from your primary care physician. We encourage you to involve your primary care physician in your health care treatment.</p> <ul style="list-style-type: none"><li>• Here are some other things you should know about specialty care: you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan. If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.</li><li>- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician can help decide what treatment you need. If your current specialist does not participate with us, if you receive treatment from a specialist who does participate with the New West Network of providers your Point of Service benefit will apply.</li></ul>

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who can arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - Terminate our contract with your specialist for reasons other than for 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,

• **Hospital care**

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

• **If you are hospitalized when your enrollment begins**

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

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

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

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

**How to get approval for...**

• **Your hospital stay**

Authorization is required if you are hospitalized immediately following emergency care or urgent care. You must request preauthorization as soon as reasonably possible, preferably on the same or next business day. If you fail to timely notify New West Health Services of your hospitalization, any request for preauthorization of your hospital stay may be denied and you may lose benefits for the health care services you receive during your hospitalization. Preauthorization may be requested from Medical Services in writing at 130 Neill Avenue, Helena, MT 59601, by telephone 800-290-3657 or by facsimile at 406-457-2298.

• **How to preauthorize an admission**

Preauthorization is required if you are hospitalized immediately following emergency care or urgent care. You must request preauthorization as soon as reasonably possible, preferably on the same or next business day. If you fail to timely notify New West Health Services of your hospitalization, any request for preauthorization of your hospital stay may be denied and you may lose benefits for the health care services you receive during your hospitalization. Preauthorization may be requested from Medical Services in writing at 130 Neill Avenue, Helena, MT 59601, by telephone at 800-290-3657 or by facsimile at 406-457-2298.

- **Maternity care**                      Preauthorization is required for any hospital stay in excess of 48 hours for a -vaginal delivery or 96 hours for a cesarean section delivery. Pre-certification may be requested from Medical Services in writing at 130 Neill Avenue, Helena, MT 59601, by telephone 800-290-3657 or by facsimile at 406-457-2298.
  
- **What happens if you do not follow the preauthorization rules**                      Payment for health care services that require preauthorization will be denied if a preauthorization is not obtained prior to receiving the health care service.
  
- 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 preauthorization**                      Your physician must obtain preauthorization from us for certain services. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.  
  
We call this review and approval process "preauthorization". Your physician must obtain preauthorization when the following are true:
  - Any referral for inpatient or outpatient care where the provider is not a member of New West Health Services' provider network.
  - A member is to be confined in a hospital, skilled nursing facility, rehabilitation facility, or other institution, whether in-network or out-of-network.
  - A member requires durable medical equipment, prosthetic devices or implants.
  - Home Health Services
  - A member requires rehabilitation.
  - A member requires speech therapy.
  - Non-emergency care air ambulance service (including related ground ambulance service).
  - A second and any subsequent prenatal ultrasounds
  - Ground ambulance for a non-emergency care transfer from one facility to another facility.
  - Neuropsychiatric and neuropsychological testing
  - Reconstructive surgery

If the services are to be provided by a participating provider, the participating provider will obtain preauthorization. If the services are to be provided by a non-participating provider, the member is responsible to obtain preauthorization, or ensure that the non-participating provider performing such services obtains the necessary preauthorization which will include the following information:

  - The member's name and group number
  - The attending physician's name, telephone number
  - The name address, and phone number of the facility the services are to be performed, if applicable
  - The exact services to be performed and justification of the medical necessity of such services
  - The scheduled date for services. Preauthorization must be requested at least seven (7) working days prior to any in- network scheduled service or procedure and 15 working days prior to any out-of-network service or procedure. If New West Health Services does not preauthorize a service by an out-of network provider, the service will not be covered at the in-network benefit level.

New West Health Services will provide verbal or written notification to the member and the provider verifying or denying such authorization. Should the member disagree with the decision, the member may appeal.

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## Section 4. Your costs for covered services

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

### **Copayments**

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

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

### **Coinsurance**

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

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

### **Cost-sharing**

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

### **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible is \$250 per person under High Option and \$0 per person under Standard Option. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$500 under High Option and \$0 under Standard Option.

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

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

### **Differences between our Plan allowance and the bill**

New West Health Services will pay the provider the plan allowance for covered services or the provider's billed amount, whichever is lower.

### **Participating Provider**

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

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

You are responsible for paying the participating provider billed charges for any health care services that are not covered services.

### **Non Participating Provider**

New West Health Services will pay the Plan allowance for the covered services less any copayments, deductibles, and/or coinsurance specified in the point-of-service benefit, see page 48.

**Your catastrophic protection out-of-pocket maximum**

After your copayments and coinsurance total the amounts shown below for self-only enrollment or family enrollment in any calendar year, you do not have to pay any more for in-network covered services, but you may have to pay more for out-of-network services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

Prosthetics and Orthotics

The amounts are:

- High Option: \$1,500 for self-only enrollment; \$3,000 for family enrollment
- Standard Option: \$5,000 for self-only or family enrollment

Be sure to keep accurate records of your copayments since you are responsible for informing us if you notice any discrepancies.

**Carryover**

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

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

**When Government facilities bill Us**

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Services are entitled to seek reimbursement for certain services and supplies provided to you or a family member. They may not seek more than the governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

## High and Standard Option Benefits - 2011

See page 10 for how our benefits changed this year. A summary of benefits for the High Option can be found on page 74 and a summary of benefits for the Standard Option can be found on page 75.

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## Section 5. High and Standard Option Benefits Overview

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This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option 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 filing advice, or more information about High and Standard Option benefits, contact us at 800-290-3657 or at our Web site at [www.newwesthealth.com](http://www.newwesthealth.com).

Each option offers unique features.

- **High Option**

- Low calendar year deductible (\$250 for self-only or \$500 for family enrollment)
- Lowest copayments for office visits and other services
- Preventive care with \$0 copayment
- Prescription drug coverage with no deductible.
- 20% coinsurance
- Out-of-pocket expenses (catastrophic limit) of \$1500 for self-only or \$3000 for family enrollment
- Point of service (POS) benefits for out-of-network services
- Nationwide provider networks for dependents living outside of the service area.
- Nationwide provider network for when you need non-emergent care outside the service area.

- **Standard Option**

- No calendar year deductible
- Low copayments for office visits and other services
- Preventive care with \$0 copayment
- Prescription drug coverage with no deductible.
- 30% coinsurance
- Out-of-pocket expenses (catastrophic limit) of \$5000 for self-only or family enrollment

## 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.
- 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.
- **High Option:** The calendar year deductible is \$250 per person (\$500 per family). Most of the benefits in this section do not apply to deductible. *We added "(Calendar year deductible applies)" to show when the calendar year deductible applies.*
- **Standard Option:** There is no calendar year deductible.

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

Benefit Description	You pay	
<b>Note: The calendar year deductible (High Option) applies only when we say below: "(Calendar year deductible applies)"</b>		
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> <li>• In a physician's office</li> <li>• In a specialist's office</li> <li>• Office medical consultation</li> <li>• In an urgent care center</li> </ul>	\$15 per visit  <i>Procedures, lab, and x-ray services are subject to annual deductible and coinsurance.</i>	\$25 per visit  <i>Procedures, lab, and x-ray services are subject to coinsurance.</i>
Other professional services of physicians <ul style="list-style-type: none"> <li>• Second surgical opinion <ul style="list-style-type: none"> <li>- Preauthorization is required</li> </ul> </li> </ul>	Nothing	Nothing
Professional services at home	\$30 per home visit	\$30 per home visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Hearing aids and related services</i></li> <li>• <i>Reverse sterilization services</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• CAT scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	20% coinsurance ( <i>Calendar year deductible applies</i> )  \$100 copayment for labs performed at a hospital or in an ambulatory surgical center. [See Section 5(c)]	30% coinsurance  \$100 copayment for labs performed at a hospital or in an ambulatory surgical center. [See Section 5(c)]
Non-routine mammograms	Nothing	Nothing

Benefit Description	You pay	
	High Option	Standard Option
<b>Preventive care, adult</b>		
Routine physical exam every year, which includes: <ul style="list-style-type: none"> <li>• Routine screenings, such as: <ul style="list-style-type: none"> <li>- Total blood cholesterol - one every three years</li> <li>- Colorectal cancer screening, including: <ul style="list-style-type: none"> <li>• Fecal occult blood test</li> <li>• Sigmoidoscopy screening - one every five years</li> <li>• Double contrast barium enema - one every five years starting at age 50</li> <li>• Colonoscopy screening - one every ten years starting at age 50</li> </ul> </li> </ul> </li> <li>- Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older</li> <li>- Routine Pap test - one annually for women</li> <li>- Routine adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC)</li> </ul>	Nothing	Nothing
Routine mammogram -- Plan pays 100% of allowed charges for: <ul style="list-style-type: none"> <li>• Women age 35 through 39 - one during this five-year period</li> <li>• Women age 40 through 64 - one every calendar year</li> <li>• Women age 65 and older - one every two consecutive calendar years</li> </ul>	Nothing	Nothing
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>	<i>All charges</i>
<b>Preventive care, children</b>		
<ul style="list-style-type: none"> <li>• Well-child care charges for routine examinations, immunizations and care (up to age 22)</li> <li>• Examinations, such as: <ul style="list-style-type: none"> <li>- Eye exams through age 17 to determine the need for vision correction [see Section 5(j)]</li> <li>- Hearing exams through age 17 to determine the need for hearing correction (does not include hearing testing and treatment)</li> <li>- Examinations done on the day of immunizations (up to age 22)</li> </ul> </li> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	Nothing	Nothing
<b>Maternity care</b>		
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul>	Nothing for prenatal care or the first postpartum care visit; \$15 per office visit for all postpartum care visits thereafter.  Nothing for inpatient professional delivery services.	Nothing for prenatal care or the first postpartum care visit; \$25 per office visit for all postpartum care visits thereafter.  Nothing for inpatient professional delivery services.

*Maternity care - continued on next page*

Benefit Description	You pay	
	High Option	Standard Option
<b>Maternity care (cont.)</b>		
<p>Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>You are not required to preauthorize your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby.</li> <li>You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. You do not need to preauthorize the normal length of stay. We will extend your inpatient stay if medically necessary.</li> <li>Newborn charges are paid like any other member benefits, except the first newborn well child exam in the hospital is covered at 100%. Surgical benefits, not maternity benefits, apply to circumcision.</li> <li>We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.</li> </ul>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Amniocentesis, non-routine ultrasound or any other procedure intended solely for gender determination</i></li> <li><i>Birth classes and/or services</i></li> <li><i>Lactation classes and/or services, including breast pumps</i></li> <li><i>Genetic selection services</i></li> <li><i>Planned delivery in your home</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Family planning</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>Diaphragms - visit for fitting and prescription <ul style="list-style-type: none"> <li>Oral contraceptives and diaphragms are covered under the prescription drug benefit.</li> </ul> </li> </ul>	\$15 copay per office visit	\$25 copay per office visit
<p>Surgical implantation of Intrauterine Devices (IUDs). (See Surgical procedures, Section 5b.)</p> <p>Surgical implantation of contraceptive devices. (See Surgical procedures, Section 5b.)</p>	\$100 copay	\$100 copay
<p>Voluntary sterilization</p> <p>Coverage is provided only once per lifetime.</p>	You pay nothing for the first \$300 of allowed charges; after that, 20% coinsurance ( <i>Calendar year deductible applies.</i> )	You pay nothing for the first \$300 of allowed charges; after that, 30% coinsurance.
<p>Injectable contraceptive drugs (such as Depo provera)</p>	20% coinsurance	30% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Reversal of voluntary surgical sterilization</i></li> <li><i>Genetic counseling</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
Infertility services	High Option	Standard Option
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>- intravaginal insemination (IVI)</li> <li>- intracervical insemination (ICI)</li> <li>- intrauterine insemination (IUI)</li> </ul> </li> </ul> <p><u>Limits:</u></p> <ul style="list-style-type: none"> <li>• Limited infertility services to the extent preauthorized by New West Health Services, including testing, appropriate medical advice, and instruction in accordance with accepted medical practice.</li> <li>• Treatment for infertility is covered only for members who have been diagnosed as biologically infertile in accordance with accepted medical practice.</li> <li>• Three artificial inseminations per member per lifetime. If after three attempts per lifetime the member fails to conceive, no additional inseminations will be covered.</li> </ul>	20% coinsurance ( <i>Calendar year deductible applies</i> )	30% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Fertility drugs</li> <li>• Surrogate parentage</li> <li>• Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> <li>- <i>in vitro</i> fertilization</li> <li>- embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)</li> </ul> </li> <li>• Services and supplies related to ART procedures</li> <li>• Cost of donor sperm</li> <li>• Cost of donor egg</li> <li>• Gene manipulation therapy</li> </ul>	<i>All charges</i>	<i>All charges</i>
Allergy care	High Option	Standard Option
Testing	\$15 per office visit  Any lab and/or x-ray charges are subject to 20% coinsurance. ( <i>Calendar year deductible applies.</i> )	\$25 per office visit  Any lab and/or x-ray charges are subject to 30% coinsurance.
Treatment <ul style="list-style-type: none"> <li>• Allergy injections</li> </ul>	20% coinsurance ( <i>Calendar year deductible applies</i> )	30% coinsurance
Allergy serum	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Provocative food testing</i></li> <li>• <i>Sublingual allergy desensitization</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 31.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis -- hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV) / infusion therapy -- Home IV and and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We only cover GHT when we preauthorize the treatment. Call the Preauthorize line at 800-290-3657.</p> <ul style="list-style-type: none"> <li>• Pulmonary therapy (15 visits per year combined with cardiac rehabilitation)</li> </ul>	20% coinsurance ( <i>Calendar year deductible applies</i> )	30% coinsurance
Physical and occupational therapies	High Option	Standard Option
<p>For the following services:</p> <ul style="list-style-type: none"> <li>• Qualified physical therapists and</li> <li>• Occupational therapists</li> <li>• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction (15 visits per year combined with pulmonary therapy)</li> </ul> <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><u>Limits:</u></p> <ul style="list-style-type: none"> <li>• 60 visits annual benefit maximum (not combined) for physical therapy</li> <li>• 60 visits annual benefit maximum (not combined) for occupational therapy</li> </ul>	20% coinsurance ( <i>Calendar year deductible applies</i> )	30% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Long-term rehabilitative therapy</i></li> <li>• <i>Exercise programs</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
Speech therapy	High Option	Standard Option
<ul style="list-style-type: none"> <li>60 visits annual benefit maximum</li> </ul>	20% coinsurance ( <i>Calendar year deductible applies</i> )	30% coinsurance
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
Audiology testing	20% coinsurance ( <i>Calendar year deductible applies</i> )	30% coinsurance
Hearing testing for children through age 17, as shown in <i>Preventive care, children</i> ;	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Hearing aids, testing and examinations for them</li> <li>Cochlear implants</li> <li>- If a medically necessary surgery is required, New West Health Services will pay for the medically necessary surgery even though the implant is not covered.</li> </ul>	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> <li>One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> <li>This plan includes vision benefits; see Section 5(j)</li> <li>See Preventive care, children for vision screening exam for children.</li> </ul>	20% coinsurance ( <i>Calendar year deductible applies</i> )	30% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Eyeglasses or contact lenses, except as shown above</li> <li>Eye exercises and orthoptics</li> <li>Radial keratotomy and other refractive surgery</li> </ul>	<i>All charges</i>	<i>All charges</i>
Foot care	High Option	Standard Option
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	20% coinsurance ( <i>Calendar year deductible applies</i> )	30% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>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</li> <li>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)</li> </ul>	<i>All charges</i>	<i>All charges</i>
Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> <li>Artificial limbs and eyes; stump hose</li> <li>Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> <li>Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast prosthesis following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device.</li> </ul>	20% coinsurance ( <i>Calendar year deductible applies</i> )	30% coinsurance

*Orthopedic and prosthetic devices - continued on next page*

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	High Option	Standard Option
<p><u>Limits:</u></p> <ul style="list-style-type: none"> <li>• <b>Must be preauthorized by New West Health Services.</b></li> <li>• Prosthetics and Orthotics do not apply to Out-of-Pocket Maximum. (This means you will always pay coinsurance.)</li> </ul>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Foot orthotics</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li>• <i>Cochlear implants</i></li> <li>• <i>Penile prostheses</i></li> </ul> <p><i>Note: If a medically necessary surgery is required, New West Health Services will pay for the medically necessary surgery even though the item listed above is not covered.</i></p> <ul style="list-style-type: none"> <li>• <i>Prosthetics for cosmetic purposes, dental braces, orthotic devices for podiatric use and arch support, braces used as aids in sports and activities, corsets and other non-rigid appliances</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)	High Option	Standard Option
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> <li>• Oxygen</li> <li>• Dialysis equipment</li> <li>• Hospital beds</li> <li>• Wheelchairs</li> <li>• Crutches</li> <li>• Walkers</li> <li>• Blood glucose monitors</li> <li>• Insulin pumps</li> <li>• Pain control devices</li> <li>• Oxygen concentrators</li> <li>• Bone growth stimulators</li> <li>• Customized braces</li> <li>• Motorized transportation devices, including, but not limited to, motorized wheelchairs and scooters</li> <li>• CPAP (continuous positive airway pressure) devices</li> <li>• BiPAP (bilevel positive airway pressure) devices</li> <li>• Oral devices (known as mandibular advancement devices) when a treatment trial using a CPAP or BiPAP device fails or is otherwise prohibited</li> </ul>	20% coinsurance ( <i>Calendar year deductible applies</i> )	30% coinsurance

*Durable medical equipment (DME) - continued on next page*

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<p><u>Limits:</u></p> <ul style="list-style-type: none"> <li>• Durable Medical Equipment does not apply to Out-of-Pocket Maximum. (This means you will always pay coinsurance.) <ul style="list-style-type: none"> <li>- \$3000 annual benefit maximum</li> <li>- Insulin pumps (rental/purchase) do not apply to the annual benefit maximum</li> <li>- \$500 annual benefit maximum for an oral device and related health care services for treatment of sleep apnea</li> <li>- Durable medical equipment must be prescribed by a provider</li> <li>- The member must provide proof of medical necessity</li> </ul> </li> </ul> <p>Preauthorization is required when the specific DME cost is \$500 or more. The preauthorization will be for specific DME and for a specific period of time. The preauthorization will state whether purchase or rental is approved. After the initial preauthorization period of coverage expires, continuation of coverage is subject to written preauthorization in advance for another specified period.</p> <p>Please call us at 800-290-3657 as soon as your Plan physician prescribes this equipment.</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Environmental modification to home or place of residence</i></li> <li>• <i>Non-prescribed or over-the-counter appliances</i></li> <li>• <i>Equipment for personal comfort, convenience or spare</i></li> <li>• <i>Penile prosthesis (medically necessary surgery is covered), for cosmetic purposes, dental braces, orthotic devices for podiatric use and arch support, braces used as aids in sports and activities, corsets and other non-rigid appliances</i></li> <li>• <i>Maintenance or replacement due to loss, theft or destruction of external prosthesis</i></li> <li>• <i>Batteries or routine supplies needed for the operation or maintenance of the DME equipment purchased, including, but is not limited to, oxygen tubing, CPAP and nebulizer filters</i></li> <li>• <i>Repair or maintenance of DME once purchased</i></li> <li>• <i>Breast pumps</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Home health services	High Option	Standard Option
<ul style="list-style-type: none"> <li>• 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.</li> <li>• Services include oxygen therapy, intravenous therapy and medications.</li> </ul> <p>Note: Must be preauthorized by New West Health Services.</p>	20% coinsurance ( <i>Calendar year deductible applies.</i> )	30% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

*Home health services - continued on next page*

Benefit Description	You pay	
Home health services (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> <li>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</li> </ul>	All charges	All charges
Chiropractic	High Option	Standard Option
<ul style="list-style-type: none"> <li>Exam including: <ul style="list-style-type: none"> <li>Manipulation of the spine and extremities</li> </ul> </li> </ul>	\$15 per office visit	\$25 per office visit
<ul style="list-style-type: none"> <li>Procedures including: <ul style="list-style-type: none"> <li>Ultrasound</li> <li>Electronic muscle stimulation</li> <li>Vibrator therapy</li> <li>Hot/Cold pack application</li> <li>x-rays</li> </ul> </li> </ul>	20% coinsurance ( <i>Calendar year deductible applies.</i> )  All services exceeding \$500 annual benefit maximum for Chiropractic and Alternative treatments combined.	30% coinsurance  All services exceeding \$500 annual benefit maximum for Chiropractic and Alternative treatments combined.
Alternative treatments	High Option	Standard Option
Coverage is provided when received from licensed providers: <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Naturopathic office visits</li> <li>Massage therapy</li> </ul>	\$15 per office visit  All services exceeding \$500 for Chiropractic and Alternative treatments combined.	\$25 per office visit  All services exceeding \$500 for Chiropractic and Alternative treatments combined.
Educational classes and programs	High Option	Standard Option
Coverage is provided for:  Smoking cessation programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year and up to four counseling sessions per quit attempt.  Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year and up to four counseling sessions per quit attempt.  Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
Coverage is provided for:  Diabetes self management	All charges exceeding \$250 annual benefit	All charges exceeding \$250 annual benefit
Coverage is provided for:  Childhood obesity education	Nothing	Nothing



Benefit Description	You pay	
	High Option	Standard Option
<p><b>Surgical procedures (cont.)</b></p> <p>4. The patient is an appropriate candidate for surgery having risks of surgery weighed against benefits.</p> <p>5. The patient is an appropriate psychological candidate for surgery having been evaluated by a mental health professional.</p> <ul style="list-style-type: none"> <li>• Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information.</li> <li>• Treatment of burns</li> </ul> <p>Note: Generally, we pay for internal prosthetics (devices). For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	\$100 copay (Calendar year deductible applies.)	\$100 copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care.</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<p><b>Reconstructive surgery</b></p> <ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>- the condition produced a major effect on the member's appearance and</li> <li>- the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• 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.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>- surgery to produce a symmetrical appearance of breasts;</li> <li>- treatment of any physical complications, such as lymphedemas;</li> <li>- breast prosthesis and surgical bras and replacements (see Prosthetic devices)</li> <li>- breast reduction surgery.</li> </ul> </li> </ul> <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.</p>	20% coinsurance (Calendar year deductible applies.)	30% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <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></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
Oral and maxillofacial surgery	High Option	Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures;</li> <li>• Treatment of TMJ, including surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	20% coinsurance (Calendar year deductible applies.)	30% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Organ/tissue transplants	High Option	Standard Option
<p>These <b>solid organ transplants</b> are subject to medical necessity and experimental/investigational review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Liver</li> <li>• Pancreas</li> <li>• Intestinal transplants <ul style="list-style-type: none"> <li>- Small intestine</li> <li>- Small intestine with liver</li> <li>- Small intestine with multiple organs, such as the liver , stomach, and pancreas</li> </ul> </li> <li>• Lung: single/bilateral/lobar</li> </ul>	Nothing	Nothing
<p>These <b>tandem blood or marrow stem cell transplants for covered transplants</b> are subject to medical necessity review by New West. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> <li>• Autologous tandem transplants for <ul style="list-style-type: none"> <li>- AL Amyloidosis</li> <li>- Multiple myeloma (de novo and treated)</li> <li>- Recurrent germ cell tumors (including testicular cancer)</li> </ul> </li> </ul>	Nothing	Nothing

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Organ/tissue transplants (cont.)</b></p> <p><b>Blood or marrow stem cell transplants</b> limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <p>Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal or abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Advanced Hodgkin's lymphoma with reoccurrence (relapsed)</li> <li>- Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)</li> <li>- Marrow failure and related disorders (i.e. Fanconi's PNH, pure red cell aplasia)</li> <li>- Chronic myelogenous leukemia</li> <li>- Hemoglobinopathies</li> <li>- Myelodysplasia/Myelodysplastic syndromes</li> <li>- Severe combined immunodeficiency</li> <li>- Severe or very severe aplastic anemia</li> <li>- Amyloidosis</li> <li>- Paroxysmal Nocturnal Hemoglobinuria</li> </ul> </li> <li>• Autologous transplants for <ul style="list-style-type: none"> <li>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin's lymphoma with reoccurrence (relapsed)</li> <li>- Neuroblastoma</li> <li>- Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)</li> <li>- Advanced neuroblastoma</li> <li>- Amyloidosis</li> </ul> </li> <li>• Autologous tandem transplants for <ul style="list-style-type: none"> <li>- Recurrent germ cell tumors (including testicular cancer)</li> <li>- Multiple myeloma</li> <li>- De novo myeloma</li> </ul> </li> <li>• Allogeneic transplants for</li> </ul>	Nothing	Nothing
	Nothing	Nothing

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay	
	High Option	Standard Option
<b>Organ/tissue transplants (cont.)</b> <ul style="list-style-type: none"> <li>- Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)</li> <li>• Autologous transplants for <ul style="list-style-type: none"> <li>- Multiple myeloma</li> <li>- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors</li> <li>- Breast cancer</li> <li>- Epithelial ovarian cancer</li> </ul> </li> </ul>	Nothing	Nothing
<p><b>Mini-transplants performed in a clinical trial setting</b> (non-myoablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by New West.</p> <p>Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin's lymphoma with reoccurrence (relapsed)</li> <li>- Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)</li> <li>- Acute myeloid leukemia</li> <li>- Advanced Myeloproliferative Disorders (MPDs)</li> <li>- Amyloidosis</li> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Hemoglobinopathy</li> <li>- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)</li> <li>- Myelodysplasia/Myelodysplastic syndromes</li> <li>- Paroxysmal Nocturnal Hemoglobinuria</li> <li>- Severe combined immunodeficiency</li> <li>- Severe or very severe aplastic anemia</li> </ul> </li> <li>• Autologous transplants for <ul style="list-style-type: none"> <li>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin's lymphoma with reoccurrence (relapsed)</li> <li>- Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)</li> <li>- Amyloidosis</li> <li>- Neuroblastoma</li> </ul> </li> </ul>	Nothing	Nothing

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<p>If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.</p>	Nothing	Nothing
National Transplant Program (NTP) -		
<p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. <i>We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.</i></p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except as shown above</i></li> <li>• <i>Implants of artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	20% coinsurance (Calendar year deductible applies.)	30% coinsurance
Hospital (inpatient)	Nothing	Nothing

## 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.
- In this Section, unlike Sections 5(a) and 5(b), the High Option calendar year deductible applies to only a few benefits. *We added “(Calendar year deductible applies)” when it applies.* The High Option calendar year deductible is: \$250 per person (\$500 per family). There is no deductible for the Standard Option.
- 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 PREAUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You pay	
<b>Inpatient hospital</b>	<b>High Option</b>	<b>Standard Option</b>
Room and board, such as: <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations</li> <li>• General nursing care</li> <li>• Meals and special diets</li> </ul> Other hospital services and supplies, such as: <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and x-rays</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</li> </ul>	\$100 copay (per admission)	\$150 copay per day for 5 days; Nothing thereafter
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Custodial care</i></li> <li>• <i>Non-covered facilities, such as nursing homes, schools</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i></li> <li>• <i>Private nursing care</i></li> <li>• <i>Private rooms when not medically necessary</i></li> <li>- <i>You pay the additional charge above the semiprivate room rate</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Outpatient hospital or ambulatory surgical center</b></p> <ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays , and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma , if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts , and sterile tray services</li> <li>• Medical supplies, including oxygen</li> </ul> <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.</p>	\$100 copay (per admission)	\$75 copay per day
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>	<i>All charges</i>
<p><b>Extended care benefits/skilled nursing facility benefits</b></p> <p>Extended care rehabilitation, Skilled Nursing Facilities (SNF), or Convalescent care services as follows:</p> <ul style="list-style-type: none"> <li>• Only on order of the physician or other qualified professional when preauthorize in writing by New West Health Services;</li> <li>• Only when care is in lieu of a Hospital Confinement.</li> </ul> <p>Note: Services include accommodations, meals, general nursing care, medical supplies and equipment ordinarily furnished by the facilities, and all prescribed drugs and biologicals.</p> <p><u>Limits:</u></p> <ul style="list-style-type: none"> <li>• Extended care benefits/nursing care facility benefits are limited to 60 days annual benefit maximum.</li> </ul>	\$100 copay (per admission)	\$150 copay per day for 5 days; Nothing thereafter
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Custodial care</i></li> <li>• <i>Private duty nurse</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<p><b>Hospice care</b></p> <p>When a treatment plan is submitted to New West and approved and the care is provided by a Medicare or certified state licensed Hospice agency, services in a home or hospice facility include:</p> <ul style="list-style-type: none"> <li>• Nursing care provided by or under the supervision of a registered nurse.</li> <li>• Home health aide services under the supervision of a registered nurse or specialized rehabilitative therapist.</li> <li>• Respiratory therapy and inhalation services.</li> <li>• Nutrition counseling by a nutritionist or dietitian.</li> <li>• Individual, family and caregiver counseling.</li> <li>• Medical social services.</li> <li>• Bereavement support for Member's family.</li> </ul>	20% coinsurance (Calendar year deductible applies)	30% coinsurance

*Hospice care - continued on next page*

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Hospice care (cont.)</b></p> <ul style="list-style-type: none"> <li>• Continuous home care or short-term inpatient care provided in a Participating Hospice inpatient unit, Hospital, or skilled nursing facility as required for pain control or symptom management.</li> <li>• Medical supplies ordinarily furnished by the hospice agency, including prescription drugs and biologicals.</li> </ul> <p><u>Limits:</u></p> <ul style="list-style-type: none"> <li>• For hospice care to be covered services, BOTH of the following requirements must be met: <ul style="list-style-type: none"> <li>- The hospice care is provided by a Medicare or certified state licensed hospice care agency in your home or a hospice care facility.</li> <li>- Before your hospice care starts, New West Health Services receives and reviews the hospice care treatment plan developed by the physician, physician assistant or advance practice nurse ordering the hospice services, which must include, but is not limited to, a certification from that professional that you are in the terminal stages of illness, with a life expectancy of approximately 6 months or less.</li> </ul> </li> <li>• Inpatient hospice care will be provided when either: <ul style="list-style-type: none"> <li>- There are no suitable caregivers able to provide care in your home. OR</li> <li>- It is determined that hospice care at your home is impractical because your condition cannot be adequately managed in an outpatient setting by the person(s) who regularly assist with home care, including, but not limited to, pain medication management.</li> </ul> </li> <li>• Respite care, limited to 5 consecutive days every 2 months.</li> </ul>	20% coinsurance (Calendar year deductible applies)	30% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Independent nursing, homemaker services.</i></li> <li>• <i>Private duty nursing and private duty home health aides.</i></li> <li>• <i>Health care services related to the terminal condition that are not a part of hospice care.</i></li> <li>• <i>Services of a caregiver other than the one provided by the hospice care agency, including, but not limited to, someone who lives in your home or someone who is your relative.</i></li> <li>• <i>Services that provide a protective environment where no medical or professional skill is required, including, but not limited to, companionship or sitter services.</i></li> <li>• <i>Services including domestic or housekeeping services, legal services, estate planning, funeral costs, food services (including, but not limited to, meals on wheels), and transportation services other than covered ambulance services.</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
Ambulance	High Option	Standard Option
<p>Local professional ambulance service when medically appropriate.</p> <p><u>Limits:</u></p> <ul style="list-style-type: none"> <li>• Prior authorization is required for: <ul style="list-style-type: none"> <li>- Non-emergency care air ambulance service (including related ground ambulance service).</li> <li>- Ground ambulance for a non-emergency care transfer from one facility to another facility.</li> </ul> </li> </ul>	<p>\$100 copay per trip (ground or air)</p>	<p>\$100 copay per trip (ground or air)</p>

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## Section 5(d). Emergency services/accidents

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### 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: Dial 911 or seek medical attention as soon as possible.

#### Emergencies within our service area

If a member receives medically necessary ground or air ambulance service when the destination is an acute care facility, the member will be entitled to reimbursement for any of the following:

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

When ordered by the member's attending physician, the member will be entitled to reimbursement for movement from the hospital to another facility or from the member's home for emergency situations.

#### Emergencies outside our service area:

If a member receives medically necessary emergency care outside the New West Health Services Service Area, the member will be entitled to reimbursement for:

- Reasonable and customary charges for hospital services that are covered services.
- Reasonable and customary charges for professional services that are covered benefits, including sales tax in states where such tax is allowed by law.
- Reasonable and customary charges for transportation preauthorized by New West Health Services to return the member to a participating hospital, less the cost of member's normal return trip expense.

Benefit Description	You pay	
	High Option	Standard Option
<b>Emergency within our service area</b>		
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> <li>Emergency care at an urgent care center</li> </ul>	\$15 copay	\$25 copay
<ul style="list-style-type: none"> <li>Emergency care as an outpatient at a hospital (including provider services)</li> </ul>	\$75 copay Emergency room copay is waived if admitted	\$75 copay Emergency room copay is waived if admitted
<i>Not covered:</i> <i>Elective care or non-emergency care</i>	<i>All charges</i>	<i>All charges</i>
<b>Emergency outside our service area</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> <li>Emergency care at an urgent care center</li> </ul>	\$15 copay	\$25 copay
<ul style="list-style-type: none"> <li>Emergency care as an outpatient at a hospital (including provider services)</li> </ul>	\$75 copay Emergency room copay is waived if admitted	\$75 copay Emergency room copay is waived if admitted
<i>Not covered:</i> <ul style="list-style-type: none"> <li><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></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Ambulance</b>	<b>High Option</b>	<b>Standard Option</b>
Professional ambulance service when medically appropriate. Note: See Section 5(c) for non-emergency service.	\$100 copay per trip (ground or air)	\$100 copay per trip (ground or air)

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

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are 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.
- High Option: The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when a deductible does not apply. (There is no calendar year deductible for the Standard Option.)
- 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 INPATIENT SERVICES.** 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:

We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required. We may limit your benefits if you do not obtain a treatment plan. Contact New West Health Services Medical Services Department at 130 Neill Ave, Helena MT, 59601 or by telephone 1-800-290-3657 or by fax at 406-457-2298.

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.

Benefit Description	You pay After the calendar year deductible (High Option)...	
<b>Note for High Option: The calendar year deductible applies to almost all benefits in this Section.</b>		
Professional Services	High Option	Standard Option
<p>When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> <li>• Diagnostic evaluation</li> <li>• Crisis intervention and stabilization for acute episodes</li> <li>• Medication evaluation and management (pharmacotherapy)</li> <li>• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment</li> <li>• Treatment and counseling (including individual or group therapy visits)</li> </ul>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p> <p>\$15 copay per visit</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p> <p>\$25 copay per visit</p>

*Professional Services - continued on next page*

Benefit Description	You pay After the calendar year deductible (High Option)...	
<b>Professional Services (cont.)</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>• Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling</li> <li>• Professional charges for intensive outpatient treatment in a provider's office or other professional setting</li> <li>• Electroconvulsive therapy</li> </ul>	\$15 copay per visit	\$25 copay per visit
<b>Diagnostics</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner</li> <li>• Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility</li> <li>• Inpatient diagnostic tests provided and billed by a hospital or other covered facility</li> </ul>	20% coinsurance	30% coinsurance
<b>Inpatient hospital or other covered facility</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Inpatient services provided and billed by a hospital or other covered facility</p> <p>Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services</p>	\$100 copay per admission	\$150 copay per day for 5 days; nothing thereafter
<b>Outpatient hospital or other covered facility</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Outpatient services provided and billed by a hospital or other covered facility</p> <p>Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment</p>	\$100 copay	\$100 copay
<b>Not Covered</b>	<b>High Option</b>	<b>Standard Option</b>
<i>Services we have not approved.</i>	<i>All charges</i>	<i>All charges</i>

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## Section 5(f). Prescription drug benefits

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

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

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

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

- **Who can write your prescription.** A licensed provider or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy, a non-network pharmacy, or by mail. Your out of pocket cost sharing is more when you use a non-network pharmacy.
- **We use a formulary.** When accessing the Prescription benefit you will pay:
  - High Option: \$10 for Generic Drugs, \$20 for Brand Drugs that are on the formulary, and \$40 for drugs that are not on the formulary.
  - Standard Option: \$10 for Generic Drugs, \$25 for Brand Drugs that are on the formulary, and \$50 for drugs that are not on the formulary.

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

### These are the dispensing limitations.

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

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

We offer a mail order pharmacy program where a member can access a 90 day supply of a medication for a 2 month copay, at the appropriate tier.

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.

Authorization requirements: The following prescription drugs and any generic equivalents must be authorized by us or they will not be covered: AIDS/HIV medications (e.g. Truvada, Epzicom); Anorexants, anoretics and diet aids; Antineoplastic medications (e.g. Xeloda, Temodar); Biologic Response Modifier medications (e.g. Arava, Enbrel, Remicade, Xolair); Hepatitis medications (e.g. Hepsera); Hormone medications, limited to Sandostatin, growth hormone and osteoporosis medications (e.g. Forteo); Immunomodulators (e.g. Kineret, Synagis); immunosuppressants (e.g. Amevive, Cellcept); Pulmonary Antihypertensives (e.g. Remodulin, Revatio, Flolan); Retinoid medications (e.g. Soriatane CK); Seizure control medications used for weight loss (e.g. Topamax, Zonigran); Topical Tretinoin medications for adults over age 35 (e.g. Retin-A); Unclassified/newly released medications and any drugs costing over \$1,000; and Duplicate fills, such as for a vacation or to replace lost or stolen medications (limited to twice per year and not available for narcotics).

This list is not all inclusive and may be amended from time to time; call Customer Service at 800-290-3657 to determine whether authorization is required.

## Why use generic drugs?

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

## When you do have to file a claim.

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

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Covered medications and supplies</b></p> <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"> <li>• 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>.</li> <li>• Insulin</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Drugs for sexual dysfunction</li> <li>• Contraceptive drugs and devices</li> <li>• Diabetic supplies such as needles, syringes, and lancets fall under the pharmacy benefit.</li> </ul>	<p>\$10 generic</p> <p>\$20 brand formulary</p> <p>\$40 brand non-formulary</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay. If there is a generic available and you choose to use a brand name, your copay will be at the 3<sup>rd</sup> tier (\$40).</p> <p><u>Mail Order Prescriptions:</u> With this program, you may receive up to a 90-day supply of prescription drugs, injectables and supplies (collectively referred to below as prescription drugs) through the mail. Your incentive to use this program is that you will pay 2 copayments for the 90-day supply, as opposed to 1 copayment for each 30-day supply through a retail pharmacy. Information about how to use this program is included in your enrollment packet. In addition, you may contact Customer Services for assistance with this program.</p> <p>\$20 copay for diabetic test strips</p>	<p>\$10 generic</p> <p>\$25 brand formulary</p> <p>\$50 brand non-formulary</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay. If there is a generic available and you choose to use a brand name, your copay will be at the 3<sup>rd</sup> tier (\$50).</p> <p><u>Mail Order Prescriptions:</u> With this program, you may receive up to a 90-day supply of prescription drugs, injectables and supplies (collectively referred to below as prescription drugs) through the mail. Your incentive to use this program is that you will pay 2 copayments for the 90-day supply, as opposed to 1 copayment for each 30-day supply through a retail pharmacy. Information about how to use this program is included in your enrollment packet. In addition, you may contact Customer Services for assistance with this program.</p> <p>\$25 copay for diabetic test strips</p>
<p>Not covered:</p> <ul style="list-style-type: none"> <li>• Medicines filled at local (retail) pharmacies for greater than a 34-day supply</li> <li>• More than one purchase of prescription drugs during the dosage period recommended by the provider</li> <li>• Prescription drugs received outside the United States, other than those received as part of an emergency or urgent care</li> <li>• Drugs, injectables and/or supplies that are:</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

*Covered medications and supplies - continued on next page*

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> <li>- Not approved by the United States Food &amp; Drug Administration (USDA)</li> <li>- Prescribed for a medical condition other than the medical condition(s) for which they were approved by the FDA</li> <li>- Dispensed in excess of the quantity or amount specified by the prescribing provider</li> <li>- Drugs or medications for infertility treatment</li> <li>- Non-legend drugs</li> <li>- Anabolic steroids</li> <li>- Drugs prescribed/administered for cosmetic purposes only</li> <li>- Hair growth agents</li> <li>- Vitamins, minerals, nutritional supplements, and homeopathic and herbal remedies</li> <li>- Non-prescription drugs or medicines</li> </ul> <p>Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking cessation benefit. (See page 28.)</p>	<i>All charges</i>	<i>All charges</i>

## 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 Employee Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be the First/Primary payor 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.
- High Option: The calendar year deductible is: \$250 per person (\$500 per family). The calendar year deductible applies to all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply. (There is no calendar year deductible for Standard Option.)
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.

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

Accidental injury benefit	You pay	
Accidental injury benefit	High Option	Standard Option
We cover restorative service and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	20% coinsurance after deductible	30% coinsurance
Dental benefits		
Other dental benefits	High Option	Standard Option
No other dental benefits are available.		

## Section 5(h). Special features

Feature	Description
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue.</li> <li>• Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits.</li> <li>• If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request.</li> </ul> <p>Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</p>
<b>Referrals for Specialists</b>	You are NOT required to obtain referrals to see specialists.
<b>Out of State Benefits - High Option only</b>	New West Health Services has an agreement with a national provider network. This arrangement provides “in-network” benefits for dependents outside of the service area, such as the case of a college student living in another state or when there is court ordered coverage. <b>Authorization is required to receive in-network benefits.</b> To locate a provider go to <a href="http://www.newwesthealth.com">www.newwesthealth.com</a> or call Customer Service.
<b>High risk pregnancies</b>	High Risk pregnancies are case managed by local patient care coordinators. Patient care coordinators are RN’s. We will refer patient to a center of excellence if appropriate.
<b>Centers of excellence for transplants</b>	New West Health Services requires the use of Centers of Excellence for transplants. The following transplant networks are available to choose from: Optum Health, Lifetrac, and Cigna’s LifeSource.
<b>Travel benefit/services overseas</b>	New West Health Services Members are covered as if “in-network” for emergency services anywhere in the world.
<b>MyNewWest Web Portal</b>	New West Health Services has implemented a web portal for members and providers to better manage health care outcomes, costs, and make informed customer choices. Through <a href="http://www.mynewwest.com">www.mynewwest.com</a> you have access to your claims for review, online payment of claims (you must have an eligible Health Savings Account), deductible accumulator, online health encyclopedia, symptom checker, and access to online HIPAA privacy compliance forms.
<b>Optum Health Wellness Program</b>	Optum Health and New West Health Services encourages members to take an active part in managing their own health outcomes. Optum Health offers a wellness program designed to help individuals maintain good health and prevent disease or progression of conditions by adopting a healthy lifestyle, lowering health threats, and increasing the use of proven clinical preventive medical services. Optum Health provides members with an online health risk assessment tool to help members quantify their personal health risks. Health promotion is primarily non-medical and focus on behavior change.

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## Section 5(i) Point of Service benefits - High Option Only

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### **Facts about the High Option Plan's Point of Service Benefit**

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

### **What is covered**

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

- Medical office visits
- Preventive health services, including well baby and well child care, routine periodic preventive health examinations, immunizations, allergy testing and treatment, and allergy serum
- Emergency services
- X-ray and laboratory services
- Acute inpatient hospital services
- Maternity, pregnancy and newborn care
- Inpatient physician services and consultations
- Outpatient hospital services
- Outpatient surgery
- Home health care
- Skilled nursing facility services
- Mental health services
- Inpatient chemical dependency services
- Inpatient alcohol treatment
- Durable medical equipment and prosthetic devices
- Orthopedic appliances
- Outpatient rehabilitative therapy
- Oral surgery

### **Plan Preauthorization**

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

### **Deductible**

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

## **Coinsurance**

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

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

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

## **Out-of-Pocket Maximum**

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

## **Emergency Benefits**

Medically necessary emergency care (even if received from a non-participating provider) is always covered as an in-network benefit. See Section 5(d).

## **What is Not Covered**

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

Prescription drugs

Services that are experimental or investigational.

Services that are not medically necessary.

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

## **How to Obtain Benefits**

If you receive services from a non-participating provider, the provider may file a claim directly with us. If the provider files a claim, payment generally will be made directly to the provider. However, we may pay you, even if the provider filed the claim. In that case, you are responsible for paying the provider. If the provider requires you to pay up front and will not submit a claim for you, you should submit a claim to us for reimbursement. See page 52 for instructions on how to file a claim. You must submit a complete claim form by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that Government administrative operations or legal incapacity prevented you from filing on time.

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## Section 5(j) Non-FEHB benefits available to Plan members

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The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, 800-290-3657 or visit their website at [www.newwesthealth.com](http://www.newwesthealth.com).

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

The vision benefits are as follows:

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

### How to Submit Claims

Participating providers will submit the claims for you.

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

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

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

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Items specifically listed as not covered in this brochure;
- Services, drugs, or supplies you receive without charge while in active military service;
- Extra care costs related to taking part in a clinical trial such as additional tests needed as part of the trial but not needed as part of routine care; or
- Research costs related to conducting clinical trials such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

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## Section 7. Filing a claim for covered services

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There are four types of claims. Three of the four types - Urgent care claims, Pre-service claims, and Concurrent review claims - usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims/requests and Section 10 for the definitions of these three types of claims.

The fourth type - Post-service claims - is the claim for payment of benefits after services or supplies have been received.

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 CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call Customer Services at 800-290-3657.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the CMS-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 payor – such as the Medicare Summary Notice (MSN); and
  - Receipts, if you paid for your services.
- Submit your claims to: **New West Health Services, P.O. Box 548, Kalispell, MT 59901**

Sample claims forms are available by calling Customer Service at 800-290-3658 or at [www.newwesthealth.com](http://www.newwesthealth.com).

### **Prescription drugs**

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

Sample claims forms are available by calling Customer Services at 800-290-3658 or at [www.newwesthealth.com](http://www.newwesthealth.com).

### **Other supplies or services**

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

Sample claims forms are available by calling Customer Services at 800-290-3658 or at [www.newwesthealth.com](http://www.newwesthealth.com)

### **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.

**Urgent care claims procedures**

If you have an urgent care claim, please contact our Customer Service Department at 1-800-290-3657. Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with a written or electronic notification within three days of oral notification.

**Concurrent care claims procedures**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

**Pre-service claims procedures**

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

**Post-service claims procedures**

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

**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. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

**Authorized  
Representative**

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

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## Section 8. The disputed claims process

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Please 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. You may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we do not follow the particular requirements of this disputed claims process. For more information about situations in which you are entitled to immediately appeal and how to do so, please visit [www.newwesthealth.com](http://www.newwesthealth.com).

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

- 1** Ask us in writing to reconsider our initial decision. You must:
  - a) Write to us within 6 months from the date of our decision; and
  - b) Send your request to us at: New West Health Services, 130 Neill Avenue, Helena, MT 59601; and
  - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
  - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
  - e) Include your email address (optional) if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

- 2** We have 30 days from the date we receive your request to:
  - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
  - b) Write to you and maintain our denial - go to step 4; or precertify your hospital stay or grant your request for prior approval for a service, drug, or supply;

Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

In the case of an appeal of an urgent care claim, we will notify you or our decision not later than 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- 4** If you do not agree with our decision, you may ask the United States Office of Personnel Management (OPM) to review it.

You must write to OPM within

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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 preauthorization 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 you did not indicate that your claim was a claim for urgent care, then call us at 1-888-500-3355. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3at (202) 606-0755 between 8 a.m. and 5 p.m. eastern time.

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## Section 9. Coordinating benefits with other coverage

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### **When you have other health coverage**

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault.

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

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

When we are the secondary payor, 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 f(1-800-633-4227), (TTY 1-877-486-2048) or more information.
- **Part B (Medical Insurance).** Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- **Part C (Medicare Advantage).** You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- **Part D (Medicare prescription drug coverage).** There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-877-486-2048). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

### **• Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY 1-800-325-0778) 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 did not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up any time, while you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B when Medicare is primary. This is true whether or not they accept Medicare.

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.

**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 payor, we process the claim first.

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

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

**Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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) (TTY 1-877-486-2048) or at [www.medicare.gov](http://www.medicare.gov).

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

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

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

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

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

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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.)**

<b>Primary Payor Chart</b>		
<b>A. When you - or your covered spouse - are age 65 or over and have Medicare and you...</b>	<b>The primary payor for the individual with Medicare is...</b>	
	<b>Medicare</b>	<b>This Plan</b>
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>B. When you or a covered family member...</b>		
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 <b>(30-month coordination period)</b>		✓
• 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 payor before eligibility due to ESRD <b>(for 30 month coordination period)</b>		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD <b>(for the 30 month coordination period)</b>		✓
• Medicare based on ESRD <b>(after the 30 month coordination period)</b>	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you...</b>		
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	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>		
	✓	

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

**TRICARE and CHAMPVA**

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

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

**Workers' Compensation**

We do not cover services that:

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

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

**Medicaid**

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

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

**When other Government agencies are responsible for your care**

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

**When others are responsible for injuries**

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

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

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

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

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

**Clinical Trials**

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab test, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by the plan.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

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## Section 10. Definitions of terms we use in this brochure

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<b>Calendar year</b>	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.
<b>Clinical Trial Cost Categories</b>	<ul style="list-style-type: none"><li>• Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.</li><li>• Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.</li><li>• Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.</li></ul>
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 15.
<b>Cost-sharing</b>	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.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Deductible</b>	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 15.
<b>Experimental or investigational service</b>	Medical, surgical or psychiatric procedures, treatments, devices and pharmacological regimes (including investigational drugs and drug therapies) determined by the medical community at large, including the United States Food and Drug Administration, or Medicare, or recognized review sources ( such as Hayes, DATTA, etc.) to be experimental, investigational or unproven. New West Health Services, in its sole discretion, shall have the authority to determine from time to time pursuant to the terms, conditions, and procedures set forth in Utilization Review Plan what are considered to be experimental, investigational, unproven, unusual, or not customary treatments, procedures, devices, and/or drugs.
<b>Health care Professional</b>	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
<b>Medically Necessary</b>	"Medically Necessary" means those Covered Services, as determined by New West Health Services on a case-by-case basis, that are appropriate and necessary to meet basic health needs and/or improve the health status of a Member. To qualify as Medically Necessary, a Covered Service or supply must be: <ul style="list-style-type: none"><li>• Not Experimental, Investigational, Unproven, Unusual or Not Customary Treatments, Procedures, Devices, and/or Drugs;</li><li>• Consistent with the diagnosis of and prescribed course of treatment for the Member's condition;</li><li>• Consistent with sound and valid standards for preventive care;</li><li>• Required to prevent the Member's condition from worsening;</li><li>• Consistent with the local medical standards of the community and considered appropriate for the Member's condition; and</li><li>• Performed in the most cost efficient type of setting appropriate for the condition.</li></ul>

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

**Plan allowance**

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

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

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

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

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

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

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

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

**Post-service claims**

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

**Pre-service claims**

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

**Urgent care claims**

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or

- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-290-3657. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

**Us/We**

Us and We refer to New West Health Services.

**You**

You refers to the enrollee and each covered family member.

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## Section 11. FEHB Facts

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### 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](http://www.opm.gov/insure/health) for enrollment information as well as:

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

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

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Several provisions of the Affordable Care Act (ACA) affect the eligibility of family members under the FEHB Program effective January 1, 2011.

<b>Children</b>	<b>Coverage</b>
Between ages 22 and 26	Children between the ages of 22 and 26 are covered under their parent's Self and Family enrollment up to age 26.
Married Children	Married children (but NOT their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
Stepchildren	Stepchildren do not need to live with the enrollee in a parent-child relationship to be eligible for coverage up to age 26.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Foster Children	Foster children are eligible for coverage up to age 26.

You can find additional information at [www.opm.gov/insure](http://www.opm.gov/insure).

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, 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 26 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 26 turns age 26.

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.

You can find additional information at [www.opm.gov/insure](http://www.opm.gov/insure).

- **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 2011 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 2010 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.

If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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 31<sup>st</sup> 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 60<sup>th</sup> 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](http://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 26 .

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](http://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](http://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.

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## Section 12. Three Federal Programs complement FEHB benefits

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### 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, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) 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 tax dependents including adult children (through the end of the calendar year in which they turn 26) 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.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

#### Where can I get more information about FSAFEDS?

Visit [www.FSAFEDS.com](http://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 separate and different from the FEHB Program, and was 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/vision](http://www.opm.gov/insure/vision) and [www.opm.gov/insure/dental](http://www.opm.gov/insure/dental). These sites also provide 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](http://www.BENEFEDS.com). For those without access to a computer, call 1-877-888-3337(TTY 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 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. 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. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

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## Summary of benefits for New West Health Services High Option - 2011

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay (In-Network)	Page
<b>Medical services provided by physicians:</b>		
Diagnostic and treatment services provided in the office	\$15 Office Visit copay	20
<b>Services provided by a hospital:</b>		
• Inpatient	\$100 per admission copay	35
• Outpatient	\$100 per admission copay	36
<b>Emergency benefits:</b>		
• In-area	\$75 per emergency room visit	40
• Out-of-area	\$75 per emergency room visit	40
<b>Mental health and substance abuse treatment:</b>	Regular cost-sharing	41
<b>Prescription drugs:</b>		
• Retail pharmacy	\$10 generic, \$20 brand, \$40 brand non-formulary	43
• Mail order	2 copayments for 90-day supply	44
<b>Dental Care:</b>	Accidental injury only	46
<b>Vision care:</b>	20% coinsurance (Calendar year deductible applies)	25
<b>Special features:</b>	Out of State Benefits, Travel Benefit, Centers of Excellence, MyNewWest web portal, OptumHealth wellness program	46
<b>Point of Service benefits:</b>	\$500 self only/\$1000 family deductible 30% coinsurance up to the \$2,000 self only /\$4,000 out-of-pocket maximum (High Option only)	48
<b>Protection against catastrophic costs (out-of-pocket maximum):</b>	Nothing after \$1,500 self-only/\$3,000 family	16

## Summary of benefits for New West Health Services Standard Option-2011

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay (In-Network)	Page
<b>Medical services provided by physicians:</b>		
<ul style="list-style-type: none"> <li>• Diagnostic and treatment services provided in the office</li> </ul>	\$25 Office visit copay	20
<b>Services provided by a hospital:</b>		
<ul style="list-style-type: none"> <li>• Inpatient</li> </ul>	\$150 per day copay for 5 days; nothing thereafter	35
<ul style="list-style-type: none"> <li>• Outpatient</li> </ul>	\$75 per day copay	36
<b>Emergency benefits:</b>		
<ul style="list-style-type: none"> <li>• In-area</li> </ul>	\$75 per emergency room visit	40
<ul style="list-style-type: none"> <li>• Out-of-area</li> </ul>	\$75 per emergency room visit	40
<b>Mental health and substance abuse treatment:</b>	Regular cost-sharing	41
<b>Prescription drugs:</b>		
<ul style="list-style-type: none"> <li>• Retail pharmacy</li> </ul>	\$10 generic, \$25 brand, \$50 brand non-formulary	43
<ul style="list-style-type: none"> <li>• Mail order</li> </ul>	2 copayments for 90 day supply	44
<b>Dental Care:</b>	Accidental injury only	46
<b>Vision care:</b>	30% coinsurance	25
<b>Special features:</b>	Travel benefits, Centers of Excellence, MyNewWest web portal, OptumHealth wellness program	47
<b>Protection against catastrophic costs (out-of-pocket maximum):</b>	Nothing after \$5,000 self-only or family	16

## Rate Information for New West Health Services - 2011

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
<b>High Option Self Only</b>	NV1	\$180.66	\$84.50	\$391.43	\$183.08	\$203.24	\$61.92
<b>High Option Self and Family</b>	NV2	\$403.98	\$197.18	\$875.29	\$427.22	\$454.48	\$146.68
<b>Standard Option Self Only</b>	NV4	\$157.16	\$52.38	\$340.50	\$113.50	\$177.06	\$32.48
<b>Standard Option Self and Family</b>	NV5	\$370.57	\$123.52	\$802.90	\$267.63	\$417.51	\$76.58