Western Health Advantage

www.westernhealth.com/FEHB

Customer Care Center 888-563-2250

2026

A Health Maintenance Organization (High Option)

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9, FEHB Facts for details. This Plan is accredited. See Section 1, How This Plan Works, page 14.

IMPORTANT
- Rates: Back Cover
- Changes for 2026: Page 18
- Summary of Benefits: Page 88

Serving: Northern California
Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 16. for requirements.

Enrollment codes for this Plan:

W51 High Option – Self Only
W53 High Option – Self Plus One
W52 High Option – Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-936

Important Notice from Western Health Advantage About
Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that Western Health Advantage's 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. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent 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 will 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 (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website to see if you would be subject to this additional premium.

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

- Visit www.medicare.gov for personalized help.

Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of the High Option under Western Health Advantage contract (CS 2969) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Care Center may be reached at 888-563-2250 or through our website: www.westernhealth.com/FEHB. If you are deaf, hearing impaired or speech impaired, you can contact our Customer Service at 888-563-2250, TTY 711. If you need ASL providers see our website at www.westernhealth.com/FEHB. The address for Western Health Advantage's administrative office is:

Physical Address
Western Health Advantage
2349 Gateway Oaks Drive Suite 100
Sacramento, CA 95833

Mailing Address
Western Health Advantage
2349 Gateway Oaks Drive Suite 100
Sacramento, CA 95833

This brochure is the official statement of benefits. No verbal 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 Plus One or 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, 2026, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2026, and changes are summarized in Section 2, Changes for 2026, page 18. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

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

Stop Health Care Fraud!

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

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

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

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

- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- 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 888-563-2250 and explain the situation.
  - If we do not resolve the issue:

CALL THE HEALTH CARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise) or
  - Your child age 26 or over (unless they are was disabled and incapable of self-support prior to age 26). A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a family member, 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 (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- 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 by your provider for services received. 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 is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex (pregnancy or genetic information). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex (pregnancy, or genetic information).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks.

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 take notes, ask questions and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- 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 medication is what the doctor ordered. Ask the pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understanding both the generic and brand names for all of your medication(s) is important. This helps ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you avoid taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

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

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 or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers. 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 healthcare providers and improve the quality of care you receive.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these conditions may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events".

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

Western Health Advantage and our providers are committed to preventing Healthcare Acquired Conditions (HAC). In the event a claim is submitted to Western Health Advantage for hospital services, which includes a serious reportable event, hospital-acquired condition, or other "never event", the charges related to this event will be excluded from the calculation of the member share of cost and will not be reimbursed to the provider. The charges related to the event must be written off by the hospital as part of the contractual discounted allowance.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC). Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

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

  See www.opm.gov/healthcare-insurance 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 that 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, give you other plans' brochures 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
  - When the next Open Season for enrollment begins

  We do not 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.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse, and your children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. 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 Plus One or 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 Plus One or 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 Plus One or 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members are enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member, as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: 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.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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 processed according to the 2026 benefits of your prior plan or option**. If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. **However**, if your prior plan left the FEHB Program at the end of 2025, you are covered under that plan's 2025 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 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

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

- **Upon divorce**

If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment.

You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member 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 information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

If you leave Federal service, Tribal employment, 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 or Tribal job, if you are a covered dependent child and you turn 26, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health Plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **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 or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 888-563-2250 or visit our website www.westernhealth.com/FEHB.

- **Health Insurance Marketplace** — If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.Healthcare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a (health maintenance organization (HMO) Plan). OPM requires that FEHB Plans be accredited to validate that Plan operations and/or care management meet nationally recognized standards. Western Health Advantage is Accredited by the National Committee for Quality Assurance (NCQA)www.ncqa.org. To learn more about this Plan's accreditation, please visit the following website: westernhealth.com/FEHB. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. Important contact information such as phone numbers and locations are listed on our website at westernhealth.com/FEHB.

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.

At the time of enrollment, you are required to select a primary care provider from one of the medical groups in our network. You can choose Your primary care provider will provide most of your healthcare or give you a referral to see a specialist.

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

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

General Features of our High Option Plan

- No Deductible
- Primary Care Provider Office or Virtual Visit - $25 copay
- Specialist Office or Virtual Visit - $25 copay
- Acupuncture Care - $15 copay, up to 20 visits per year
- Chiropractic Care - $15 copay, up to 20 visits per year
- Hearing Examinations - $25 copay
- Routine Vision Exam - $25 copay
- Diagnostic services - $0
  - Laboratory tests
  - X-ray and diagnostic imaging
  - Imaging (CT/PET scans and MRIs)
- Urgent Care Center - $35 copay
- Emergency Room - $100 copay
- Ambulance - $0
- Inpatient Hospital Facility Charge - $500 copay per admission
- Outpatient Hospital Facility Charge - $100 copay per occurrence
- Physician Charges and Related Services - $0
- Skilled Nursing Facility - $500 copay per admission
- Durable Medical Equipment - 20%
- Physical/Speech/Occupational Therapies - $20 copay
- Catastrophic Protection Maximum:

- $2,500 Self Only enrollment
- $5,000 Self Plus One
- $5,000 Self and Family

- Prescription Drug Coverage
  - Retail Pharmacy (cost per 30-day supply)
    - Tier 1: Preferred Generics and certain Preferred Brands - $15 copay
    - Tier 2: Preferred Brands name and certain Non-Preferred Generics - $50 copay
    - Tier 3: Non-Preferred (generic or brands) - $75 copay
  - Home delivery pharmacy (cost per prescription, up to 100-day supply)
    - Tier 1: Preferred Generics and certain Preferred Brands - $30 copay
    - Tier 2: Preferred Brands name and certain Non-Preferred Generics - $100 copay
    - Tier 3: Non-Preferred (generic or brands) - $150 copay
  - Specialty Pharmacy (cost per prescription, up to a 30-day supply)
    - Tier 4: Specialty and other higher-cost medication - $250 copay

Specialty medication must be ordered through Optum Specialty Pharmacy

Preventive care services

Preventive care services are generally covered with no cost sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

HHS: www.healthcare.gov/coverage/preventive-care-benefits/

How We Pay Providers

We contract with 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 cost sharing (copayments, coinsurance, and non-covered services and supplies).

Catastrophic Protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $10,600 for Self Only enrollment, and $21,200 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your rights and responsibilities

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

- Western Health Advantage has been in business since 1996
- Western Health Advantage is a not-for-profit HMO

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this plan. You can view the complete list of these rights and responsibilities by visiting our website, westernhealth.com/FEHB. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 888-563-2250, or write to Western Health Advantage, Attention Member Services, 2349 Gateway Oaks Drive, Suite 100 Sacramento CA 95833. You may also visit our website at westernhealth.com/FEHB.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.westernhealth.com/legal/privacy/ to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is limited to Colusa, El Dorado, Placer, Marin, Napa, Sacramento, Solano, Sonoma and Yolo counties in Northern California.

Full counties: Marin, Napa, Sacramento, Solano, Sonoma, Solano and Yolo counties, California

Partial counties:

Colusa: 95912

El Dorado: 95613, 95614, 95619, 95623, 95633, 95634, 95635, 95636, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95726, 95762

Placer: 95602, 95603, 95604, 95626, 95631, 95648, 95650, 95658, 95661, 95663, 95668, 95677, 95678, 95681, 95703, 95713, 95722, 95736, 95746, 95747, 95765

Except in the case of an emergency, medical services must be obtained from a Western Health Advantage network provider in our service area. To verify if your provider is part of our network, go to www.westernhealth.com/search-for-providers/advanced-search/. Search by specialty, name, location, gender and/or language.

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 (See Section 5(d). Emergency Services/Accidents). We will not pay for any other healthcare services out of our service area unless the services have prior Plan approval.

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

Section 2. Changes for 2026

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

Changes to your High Option Plan:

- Your Catastrophic Out-of-Pocket Maximum increased for Self Plus One and Self and Family from $4,500 to $5,000. The Self Only catastrophic maximum will remain at $2,500. (See page 26).
- Primary Care Physician (PCP) and Specialist office visit: Your member cost shares increased from $20 to $25. (See page 32).
- Telehealth (Virtual visits): Your member cost share increased from $20 to $25. Your member cost share for virtual visits for urgent virtual visits increased from $25 to $30. (See page 32).
- Maternity Care and Delivery (Inpatient admission): Your member cost share increased from $250 per admission to $500 per admission. (See page 38).
- Infertility Services (Office or Outpatient Facility Visits): Your member cost share structure changed from 50% of Western's allowed amount to $25 for office visits and $100 for facility visits. (See page 41).
- Allergy Testing and Treatment: The member cost share increased from $20 to $25. Allergy injections will remain at $5. (See page 43).
- Treatment Therapies: The member cost share increased from $20 to $25 for Pharmacotherapy (medication management), Outpatient cardiac rehabilitation, Pulmonary rehabilitation therapy, and Applied Behavior Analysis. (See page 43).
- Physical and Occupational Therapies: The member cost share increased from $20 to $25 for physical therapy, occupational therapy, cognitive rehabilitation therapy, habilitative therapy, and speech therapy. (See page 44).
- Hearing (Testing and Exams): The member cost share increased from $20 to a $25. (See page 45).
- Vision Services (Testing, Examinations, Treatment and Supplies): The Carrier will remove the member cost share of $20 for routine annual vision testing and examination. The member cost share for vision treatment or supplies increased from $20 to $25. Coverage is limited to medically necessary diagnostic procedures or testing and accidental injury. (See page 45).
- Foot Care: The member cost share increased from $20 to $25. (See page 45).
- Orthopedic and Prosthetic Devices (Internal and External): The member cost share increased from $20 to $25. (See page 45).
- Surgical and Anesthesia Services: The member cost share increased from $20 to $25 per visit and inpatient surgical services from $250 per admission to $500 per admission ($100 per visit if performed during an outpatient visit) (See page 49).
- Inpatient Hospital: The member cost share increased for room and board from $250 per admission to $500 per admission. (See page 57).
- Extended Care/Skilled Nursing Care facility: The member cost share increased from $250 per admission to $500 per admission. Prior authorization is required, and members will continue to receive 100 days per calendar year for skilled nursing. (See page 58).
- Emergency Services (Accidents): The member cost share increased for both emergencies within and outside the service area (doctor's office) from $20 per visit to $25 per visit. The member cost share for ambulance services has been removed. (See page 60).
- Mental Health and Substance Abuse Disorder: The member cost share for professional services (office or virtual) increased from $20 per visit to $25. The member cost for inpatient hospital or other covered facility increased from $250 to $500. Prior authorization is required, and services must be provided at a participating acute care facility. (See page 62).

- Prescription Drugs: The member cost share increased for prescription drug tiers as follows: (See page 64).• Tier 1: Preferred Generics and certain Preferred Brands from $10 to $15.
  • Tier 2: Preferred Brands and certain Non-Preferred Generics from $30 to $50
  • Tier 3: Non-Preferred Generics and Brands from $50 to $75
  • Tier 4: Specialty Drugs from $100 to $250
- Nutritional Counseling for Weight Management: The member cost share increased from $20 per visit to $25. (See page 34).
- Gender Dysphoria: Coverage for sex-trait surgery, drugs and chemical treatment with a diagnosis of gender dysphoria is now excluded. Members in mid-treatment may apply for an exception. (See page 21).
- Infertility Services: The Carrier will decrease the cost share for In Vitro Fertilization (IVF) related drugs from 50% of the allowed amount to the applicable drug tier as follows in Section 5(f), Prescription Drug Benefits. (See page 64).

Section 3. How You Get Care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 888-563-2250 or write to us at: Western Health Advantage, 2349 Gateway Oaks Drive, Suite 100, Sacramento CA 95833

You may also request replacement cards through our online member portal mywha.org.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments. You will not have to file claims. You can receive covered services from a participating provider with a required referral from your primary care physician.

- **Balance Billing Protection**

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the Plan brochure or for non-elective services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copayment, coinsurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are delegated through Western Health Advantage's contracted medical groups, independent practice associations (IPAs), hospital system and partners. All are contracted to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. Western Health has delegated credentialing/recredentialing functions to its contracted medical groups/IPAs.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

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

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information.

This Plan provides Care Coordinators for complex conditions. Call 888-563-2250 for assistance.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The provider directory can be found on our website at westernhealth.com/FEHB.

What you must do to get covered care

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

- **Primary care**

A primary care provider can be a family practitioner, internist or pediatrician. At the time of enrollment, you are required to select a primary care provider from one of the medical groups in our network. You can choose a different primary care provider for you and your family. Your primary care provider will provide most of your healthcare, or give you a referral to see a specialist.

We will assign you a primary care provider if you do not notify us of your selection upon enrollment. You can change your primary physician by logging into your MyWHA account or by calling 888-563-2250. Your primary care provider effective date is the first day of the month following your request. You must wait until the effective date before seeking care from your new provide or the services will not be covered.

Search a full listing of primary care physicians at westernhealth.com/FEHB. Use the search filters when you have specific needs and preferences such as gender, language spoken, race/ethnicity.

- **Specialty care**

Your primary care provider will refer you to a specialist for needed care. When you receive a referral from your primary care provider, you must return to the primary care provider after the consultation, unless your primary care provider authorized a certain number of visits without additional referrals. Your primary care provider must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.
- Your primary care provider will create your treatment plan. The provider may have to get prior authorization from their affiliated medical group beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. If they decide to refer you to a specialist, ask if you can see your current specialist.
- If your current specialist does not participate in our network, you must receive treatment from a specialist in our network. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- You may continue seeing your specialist for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:
  - we terminate our contract with your specialist for other than cause
  - we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - we reduce our service area and you enroll in another FEHB plan

Contact us at 888-563-2250, or if we drop out of the Program, contact your new plan.

- If you are in the 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.

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

Sex-Trait Modification: If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care.

Our exception process is as follows:

- Have a confirmed diagnosis of gender dysphoria by a licensed healthcare professional; and
- Be actively engaged in an ongoing course of treatment at the time of the effective date of the exclusion (January 1, 2026); and
- Have initiated either:
  - A surgical procedure or a course of staged surgical procedures; or
  - A continuous hormonal regimen that, if interrupted, would create a clinically significant risk to the member's health as determined by a licensed physician.

The exception process will be applied on a case-by-case basis. In order to apply for an exception to the CL 2025-01-b exclusion of sex-trait medical interventions/transgender services call our member services department at; 888-563-2250. You will also find more information on our member website at: westernhealth.com/FEHB.

If you disagree with this information, please contact our member services department at; 888-563-2250 to speak to a representative, or you can email us at: appeal.grievance@westernhealth.com.

Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.

- **Hospital care**

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 888-563-2250. 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;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

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

You need prior Plan approval for certain services

Since your primary care provider arranges referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*. You must get prior approval for those services listed. Failure to do so will result in denied claims and you will be responsible for the full cost of the service.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care provider has authority to refer you for services. For certain services, however, your physician must obtain approval from their affiliated medical group, or in some cases us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for some services such as but not limited to:

- Acute rehabilitation and behavioral health facility admissions

- Air ambulance and non-emergent ambulance transportation
- All bariatric-related consultations, services and surgical services
- Clinical trials
- Durable medical equipment
- Home health services, including but not limited to IV infusion, hospice
- Outpatient diagnostic procedures, including but not limited to MRIs, CT/PET scans
- Transplants
- Growth Hormone Treatment (GHT)
- Certain formulary and non-formulary prescription drugs, including Specialty Drugs

Services that are not authorized by your primary care provider's affiliated medical group or Western Health Advantage will not be covered.

- **How to request precertification for an admission or get prior authorization for other services**

First, your physician, your hospital, you, or your representative, must call us at 888-563-2250 before admission or services requiring prior authorization are rendered. Insurance eligibility and benefits are verified first to make sure you have effective coverage to ensure services are paid under your health Plan benefits.

Next, provide the following information:

- enrollee’s name and Plan identification number;
- patient’s name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility;
- and number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of 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 of the need for an extension of time before the end 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.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) 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 written or electronic notification within three days of oral notification

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 888-563-2250. You may also call OPM's FEHB 3 at 202-606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 888-563-2250. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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 before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. 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, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact your assigned medical group for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact your assigned medical group for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother’s hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

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, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Failure to Obtain Authorization for Non-Plan Providers: Your primary care Prior authorization Services from a non-participating provider (except in urgent care situations arising outside of Western Health Advantage's service area or emergency situations) Coverage is generally excluding from providers are generally If you fail to obtain Prior Authorization for any service requiring such an authorization, you, the Member, will be responsible for 100% of the total cost of services received from any Non-Plan Provider. It is the responsibility of the Member to ensure that Prior Authorization has been obtained for all services.

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.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 888-563-2250.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.
   - 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.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Costs for Covered Services

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

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., copayments) for the covered care you receive.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 20% for durable medical equipment
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc. when you receive certain services. Example: When you see your primary care physician, you pay a copayment of $25 per office visit, and when you go in the hospital, you pay $500 per admission.
Deductible	We do not have a deductible.
Differences between our Plan allowance and the bill	You should also see Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.
Your catastrophic protection out-of-pocket maximum	The out-of-pocket maximum (catastrophic protection) is the most a member or family will pay in a calendar year for covered services/medications. After your (deductible, copayments and coinsurance) reaches the out-of-pocket maximum you do not have to pay any more for covered services, with the exception of certain cost sharing for the services below which do not count toward your catastrophic protection out-of-pocket maximum. Your out-of-pocket maximum for services rendered during the 2026 calendar year is: Self Only $2,500 Self Plus One $5,000 Self and Family $5,000 Your out-of-pocket maximum may differ if you changed plans at Open Season. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services: • Routine hearing examinations and hearing aids • Routine vision examinations, excluding pediatric vision examinations • Chiropractic care
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 prior 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 prior 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 prior 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 prior 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 from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services. A participating provider means a contracted medical group, participating physician, participating hospital or other licensed health professional or licensed facility who or which, at the time care is provided to a member, has a contract in effect with Western Health Advantage to provide covered services to members. Information about participating providers may be obtained by calling Western Health Advantage Member Services at 888.563.2250 or visit westernhealth.com/FEHB.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health Plan.

Your health Plan must comply with the NSA protections that hold you harmless from surprise bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to westernhealth.com/FEHB or contact the health Plan at 888.563.2250.

Per section 2799A-5(c) of the PHS Act, section 9820(c) of the Internal Revenue Code,
section 720(c) of the Employee Retirement Income Security Act -

For more information, please visit our website at www.westernhealth.com/FEHB on:
(1) the restrictions on balance billing in certain circumstances,
(2) any applicable state law protections against balance billing,
(3) the requirements described under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and

(4) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

The Federal Flexible Spending Account Program - FSAFEDS

Healthcare FSA (HCFSA) – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. High Option Benefits

Section Summary of Benefits for the Western Health Advantage High Option.

Section 5. High Option Benefit Overview

This Plan offers a High Option. The benefit package is described in Section 5. Make sure you review the benefits that are available under the option in which you are enrolled.

The High 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 information about the High Option benefits, contact us at 888-563-2250 or on our website at www.westernhealth.com/FEHB.

The High option offers unique features.

High Option Plan Overview - The High Option is a copayment only health Plan. This plan provides upfront cost transparency. $0 deductible; $25 primary care provider office or virtual visit copayment; $25 specialist office and virtual visit copayment; $35 Urgent Care Center copayment; $100 emergency room copayment. $500 per admission for inpatient hospital facility charges. This plan includes several services covered with $0 copayment, such as:

- Annual physical examinations and well baby care
- Adult and pediatric immunizations, including those for flu and COVID-19
- Diagnostic Services
  - Laboratory tests
  - X-ray and diagnostic imaging
  - Imaging (CT Scan/PET Scans)

The calendar year catastrophic limit is $2,500 Self Only, $5,000 Self plus one or $5,000 Self and Family maximum out-of-pocket.

Western Health Advantage's High Option service area and provider network is limited to Marin, Napa, Sacramento, Solano, Sonoma, Yolo and partial zip codes in Colusa, El Dorado and Placer counties in Northern California. Except in the case of an emergency, medical services must be obtained from a Western Health Advantage network provider. To verify if your provider is part of our network, go to www.westernhealth.com/FEHB. Search by specialty, name, location, gender and/or language.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- 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.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay
Diagnostic and treatment services	**High**
Professional services of physicians • In physician's office	$25 copay - Primary Care Provider $25 copay - Specialist
Not covered: • *Treatment or services that are not authorized by a plan physician.* • *Treatment or services that are not medically necessary.*	All charges
Professional services of physicians • In an Urgent Care Center • Teladoc virtual urgent care visit • Initial examination of a newborn child • Office medical consultation • Second surgical opinion	$35 copay - Urgent Care Center $30 copay - Urgent Telodoc visit $25 copay - Primary Care Provider $25 copay - Specialist
• During a hospital stay • In a skilled nursing facility	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Telehealth Services	**High**
• Telehealth services including urgent care, Primary Care Provider and specialist services, and outpatient mental health services by a network provider. - Services will be provided via interactive audio and video communication when deemed medically appropriate by the network provider rendering the service. - For more information about Western Health Advantage's virtual urgent care services visit westernhealth.com/FEHB.	Telehealth Visit • $25 copay - Primary Care Provider Virtual • $25 copay - Specialist Virtual Visit • $30 copay - Urgent Care Virtual Visit

Benefit Description	You pay
Lab, X-ray and other diagnostic tests	**High**
Diagnostic services associated with an office visit or urgent care visit • Lab tests • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CT/PET scans • MRIs • Electrocardiogram and EEG • Ultrasound Prior Authorization: Required	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Preventive care, adult	**High**
Routine physical once annually. The following preventive services are covered at the time interval recommended at each of the links below. • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV and colorectal cancer. For a complete list of screenings go to the website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. • Individual counseling on prevention and reducing health risks. • Preventive care benefits for women such as pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at www.hrsa.gov/womens-guidelines. • To build your personalized list of preventive services go to https://health.gov/myhealthfinder.	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Routine mammogram - Frequency based on risk factors, beginning at 35 years of age a screening mammogram can be done every one to two years.	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Preventive Colonoscopy screening aged 45 to 75 years as recommended by your physician. After age 50 for non-symptomatic members every 10 years. No co-pay for preventive exams even if polyps found or biopsy is done during screening exam. Exams done due to symptoms are considered diagnostic. After polyp found, all future exams are diagnostic. Frequency of diagnostic exams based on findings.	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High**
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/imz-schedules/index.html *Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments.*	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: https://www.westernhealth.com/health-and-wellness/secure/health-living/nutrition-counseling/ • Intensive nutrition and behavioral weight-loss counseling therapy, with a nutritionist or registered dietician within your medical group. - Nutrional Counseling through medical benefits is offered with following criteria and guidelines: • Members who meet specified medical criteria, and who demonstrate a documented readiness to make nutrition and lifestyle changes, may take advantage of nutrition and dietary counseling with a Western Health Advantage network nutritionist or registered dietician in these areas of focus. • Counseling to Address Obesity - Initial Approval: 3 monthly visits - Renewal: 3 monthly visits with demonstrated Body - Mass Index (BMI) improvement • Adults with a BMI greater than 25 - Children with a BMI percentile greater than the 85th percentile for age - Initial Approval: 6 monthly visits - Renewal: 6 monthly visits with demonstrated improvement in BMI or related disease metrics • Adults with BMI greater than 25 and an obesity-related condition including but not limited to hypertension, hyperlipidemia, impaired fasting glucose, chronic back pain, knee osteoarthritis, fatty liver disease, polycystic ovary syndrome, infertility, cancer, gout, pseudotumor cerebri, gallbladder disease, obstructive sleep apnea, obstructive lung disease, lymphedema, and/or acid reflux - Adults with BMI greater than 30 - Children with a BMI percentile greater than the 95th percentile for age • Counseling to Address Eating Disorders Initial Approval: up to 18 visits initially and then as medically necessary Renewal: as needed based on PCP or behavioral health provider documentation of medical necessity to achieve medical stability	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High**
• Adults and children diagnosed with eating-related disorders (e.g. anorexia or bulimia) - Documentation of patient under the ongoing care of behavioral health provider • Counseling to Address Malnourishment and Weight Loss Initial Approval: 6 monthly visits Renewal: 6 monthly visits with demonstrated improvement in BMI or related disease metrics • Adults and children with weight loss greater than or equal to 20% in the prior 12-month period due to medical conditions other than eating disorder related - Documentation of specialist care as appropriate • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. - Real Appeal is a 52-week personalized, virtual lifestyle and weight management program that gives members everything they need to create healthy habits and reach their wellness goals. Western Health Advantage Weight Loss Program, in partnership with Real Appeal offers members the following: • Online Personalized Coaching • Success Kit – Start your health journey with electronic food scale and a digital weight scale, a balanced portion plate, and access to online fitness content — all available at no additional cost as part of your Western. • Digital Tools and Resources – online resources make it highly accessible to set goals and track your progress • Virtual Group Sessions – virtual group sessions help build a community to keep engaged. - https://www.westernhealth.com/health-and-wellness/secure/real-appeal-weight-loss/ - Livongo is for members over the age of 18 living with hypertension, Western Health Advantage teamed up with Livongo by Teladoc to deliver advanced hypertension management tools that give members a better way to manage their blood pressure. Here's what's included in the program: • An advanced blood pressure monitor sent directly to your home. It automatically uploads blood pressure readings to your secure online account, and the app provides valuable guidance and tips • Support from coaches that can help answer questions you may have on what you can do to make lifestyle changes that will help improve your blood pressure and lower your risk for complications • Easy-to-use app and dashboard, so your records are organized and accessible. Then you can share it with your doctor or care team whenever you are ready. Note: See section 5(h) for Wellness and other special Features. Note: When anti-obesity medication is prescribed see Section 5(f) or 5(f)(a), if applicable.	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High**
Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity see Section 5(b).	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Medications for work-related exposure.*	*All charges*
Preventive care, children	**High**
Well-child visits, examinations and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org. Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTap/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html. You can also find a complete list of the U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments.	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: https://www.westernhealth.com/health-and-wellness/secure/health-living/nutrition-counseling/ • Intensive nutrition and behavioral weight-loss counseling therapy, with a nutritionist or registered dietician within your medical group. - Nutrional Counseling through medical benefits is offered with following criteria and guidelines: • Members who meet specified medical criteria, and who demonstrate a documented readiness to make nutrition and lifestyle changes, may take advantage of nutrition and dietary counseling with a Western Health Advantage network nutritionist or registered dietician in these areas of focus.	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High**
• Counseling to Address Obesity - Initial Approval: 3 monthly visits - Renewal: 3 monthly visits with demonstrated Body - Mass Index (BMI) improvement • Adults with a BMI greater than 25 - Children with a BMI percentile greater than the 85th percentile for age - Initial Approval: 6 monthly visits - Renewal: 6 monthly visits with demonstrated improvement in BMI or related disease metrics • Adults with BMI greater than 25 and an obesity-related condition including but not limited to hypertension, hyperlipidemia, impaired fasting glucose, chronic back pain, knee osteoarthritis, fatty liver disease, polycystic ovary syndrome, infertility, cancer, gout, pseudotumor cerebri, gallbladder disease, obstructive sleep apnea, obstructive lung disease, lymphedema, and/or acid reflux - Adults with BMI greater than 30 - Children with a BMI percentile greater than the 95th percentile for age • Counseling to Address Eating Disorders Initial Approval: up to 18 visits initially and then as medically necessary Renewal: as needed based on PCP or behavioral health provider documentation of medical necessity to achieve medical stability • Adults and children diagnosed with eating-related disorders (e.g. anorexia or bulimia) - Documentation of patient under the ongoing care of behavioral health provider • Counseling to Address Malnourishment and Weight Loss Initial Approval: 6 monthly visits Renewal: 6 monthly visits with demonstrated improvement in BMI or related disease metrics • Adults and children with weight loss greater than or equal to 20% in the prior 12-month period due to medical conditions other than eating disorder related - Documentation of specialist care as appropriate	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
• Family centered programs when medically identified to support obesity prevention and management by an in-network provider. - Real Appeal is a 52-week personalized, virtual lifestyle and weight management program that gives members everything they need to create healthy habits and reach their wellness goals. Western Health Advantage Weight Loss Program, in partnership with Real Appeal offers members the following: • Online Personalized Coaching • Success Kit – Start your health journey with electronic food scale and a digital weight scale, a balanced portion plate, and access to online fitness content — all available at no additional cost as part of your Western.	

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High**
• Digital Tools and Resources – online resources make it highly accessible to set goals and track your progress • Virtual Group Sessions – virtual group sessions help build a community to keep engaged. - https://www.westernhealth.com/health-and-wellness/secure/real-appeal-weight-loss/ - Livongo is for members over the age of 18 living with hypertension, Western Health Advantage teamed up with Livongo by Teladoc to deliver advanced hypertension management tools that give members a better way to manage their blood pressure. Here's what's included in the program: • An advanced blood pressure monitor sent directly to your home. It automatically uploads blood pressure readings to your secure online account, and the app provides valuable guidance and tips • Support from coaches that can help answer questions you may have on what you can do to make lifestyle changes that will help improve your blood pressure and lower your risk for complications • Easy-to-use app and dashboard, so your records are organized and accessible. Then you can share it with your doctor or care team whenever you are ready. Note: See section 5(h) for Wellness and other special Features. Note: When anti-obesity medication is prescribed see Section 5(f) or 5(f)(a), if applicable. Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity see Section 5(b).	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Maternity care	**High**
Complete maternity (obstetrical) care, such as: • Prenatal and postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression	Nothing for prenatal care or the first postpartum care visit; $25 copay per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services. Delivery subject to inpatient hospital facility copay. See Section 5(c). for charges associated with the facility (i.e. hospital, surgical center, etc.)
Breastfeeding and lactation support, supplies and counseling for each birth Notes: You do not need to pre-certify your vaginal delivery; see page 22 for other circumstances, such as extended stays for you or your baby. As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits when medically indicated and board-certified lactation specialists during the prenatal and post-partum period. Your coverage includes doula services on a virtual basis. Visit westernhealth.com/FEHB.	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High**
You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Not covered: *Out-of-network nurse midwives.* *Home nurse visits not prior authorized by the Plan.*	All charges
Family planning	**High**
Contraceptive counseling on an annual basis A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage in Section 5(f). Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. • Services for voluntary female sterilization surgery not performed in connection with another procedure, such as caesarean delivery or abortion, requires prior authorization from your Primary Care Physician's affiliated medical group or some cases from Western Health Advantage.	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	**High**
• If you don't agree with a decision about an excluded medication or procedure, you or your authorized representative and your doctor can ask for a coverage request by calling the number on your member ID at 888-563-2250. Western Health Advantage Member Service Representatives can help guide you further. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Voluntary male sterilization	$25 copay - Primary Care Provider $25 copay - Specialist

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	**High**
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*
Infertility, Fertility, & Family-Building Services	**High**
When offered under your plan, infertility and fertility diagnosis and treatment services and prescribed medications are covered when authorized in advance by WHA and determined to be medically appropriate by a Participating Provider. Infertility" is defined as a condition or status characterized by any of the following: • A licensed physician's findings, based on the patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. • A person's inability to reproduce either as an individual or with their partner without medical intervention. • The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility. **Covered Services:** • **Office visits** for consultation, diagnosis or treatment of infertility or fertility with a Participating Provider. • **Basic laboratory and imaging tests** for diagnosis or evaluation of infertility or fertility. • **Genetic testing** for the prenatal diagnosis of a WHA-listed rare and severe genetic condition when a member meets one or more of the following criteria: • A personal or first degree relative with a WHA-listed genetic condition • A fetus from a member's prior pregnancy was determined to have one of the WHA-listed genetic condition • Both partners are carriers of a WHA-listed condition • One partner is a carrier of a WHA-listed genetic condition that is a dominant trait condition Note: A Member is found to be a carrier through preconception screening. If the partner is a WHA member, the partner may be covered for carrier testing. • **Outpatient procedures** for fertility-related service, whether in an office setting or outpatient facility, can include any of the following: • Diagnosis and treatment of infertility up to 3 cycles specific to Artificial insemination - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • All services related to sperm donor, including the collection of the sperm and sperm storage.	Applicable Copayments for services and prescribed medications contribute to the out-of-pocket maximum. $25 copay per visit performed in office setting (primary care/specialist) $100 copay per visit performed in facility

Infertility, Fertility, & Family-Building Services - continued on next page

Benefit Description	You pay
Infertility, Fertility, & Family-Building Services (cont.)	**High**
• Assisted Reproductive Technology (ART), which include procedures involving the transfer and/or implantation of egg/ovum/embryo including: - In Vitro Fertilization (IVF) - Zygote Intra-Fallopian Transfer (ZIFT) - Gamete Intra-Fallopian Transfer (GIFT) - Frozen Embryo Transfers - Intracytoplasmic sperm injection (ICSI) • Maternity services, including prenatal, delivery, and postnatal care, are covered for surrogates who are enrolled members of WHA. Maternity services for surrogates who are not WHA members are not covered. **Fertility drugs (See Section 5(f))** Prior Authorization: Required	Applicable Copayments for services and prescribed medications contribute to the out-of-pocket maximum. $25 copay per visit performed in office setting (primary care/specialist) $100 copay per visit performed in facility
Not covered: • Services and supplies to reverse voluntary, surgically induced infertility. • Treatment of infertility as a result of previous/prevailing elective vasectomy or tubal ligation, including, but not limited to, procedure reversal attempts and infertility treatment after reversal attempts. • Third-party reproduction, such as those involving surrogates, who are not members of WHA. • Legal fees, agency fees or gestational carrier expenses. • Ova sticks for the purposes of infertility testing. • Experimental and/or investigational diagnostic studies, procedures or drugs used to treat or determine the cause of infertility. • Inoculation of a woman with partner's white cells.	All charges
Iatrogenic Infertility Services Fertility Preservation for Iatrogenic Infertility is covered for members undergoing a medically necessary treatment (such as chemotherapy, radiation treatment, or oophorectomy), that may directly or indirectly cause iatrogenic infertility. Fertility preservation services for iatrogenic infertility include, but are not limited to, the following procedures: • Egg retrieval (including ovarian stimulation as needed) and storage of eggs or embryos • Sperm collection and storage • Cryopreservation and storage of eggs, embryos, or sperm as follows: - Until the Member reaches age 26 for Members who are under the age of 18 on the date the Member's genetic material is first cryopreserved. - Until the Member reaches the age of 26 or for three years, whichever period is longer, for a Member who is 18 years or older but not yet 26 years old on the date the Member's genetic material is first cryopreserved. - For the period of three years for a Member who is 26 years or older at the time of the Member's genetic material is first cryopreserved.	Applicable Copayments for services and prescribed medications contribute to the out-of-pocket maximum. $25 copay per visit performed in office setting (primary care/specialist) $100 copay per visit performed in facility

Infertility, Fertility, & Family-Building Services - continued on next page

Benefit Description	You pay
Infertility, Fertility, & Family-Building Services (cont.)	**High**
Medications related to fertility preservation collection procedures are covered under the Prescription Medication Benefit. This benefit covers fertility preservation services only, and does not include future implantation, or testing or treatment of infertility.	Applicable Copayments for services and prescribed medications contribute to the out-of-pocket maximum. $25 copay per visit performed in office setting (primary care/specialist) $100 copay per visit performed in facility
Allergy care	**High**
• Testing and Treatment • Allergy injections	$25 copay for testing and treatment $5 copay for allergy injections
Allergy Serum	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Treatment therapies	**High**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b), Organ/Tissue Transplants, page 52. • Dialysis - hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy - Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine medically necessary. See *Other Services under You need prior Plan approval for certain services* on page 22. Prior Authorization: Required	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
• Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/condition is provided as medically necessary and to lead to continued improvement Prior Authorization: Required	$25 copay
Osteopathic manipulative treatment Prior Authorization: Required	$15 copay This benefit does not contribute to the catastrophic out-of-pocket maximum.
Applied Behavior Analysis (ABA) • In Home • Group Visit	Nothing

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**High**
Prior Authorization: Required	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Applied Behavior Analysis (ABA) • Office Visit Prior Authorization: Required	$25 copay
Physical and Occupational therapies	**High**
Outpatient visits when determined medically necessary and to lead to continued improvement for the services of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a provider: • orders the care; • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Prior Authorization: Required	$25 copay Nothing during covered inpatient admission See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	All charges
Speech therapy	**High**
Outpatient visits when medically necessary Note: Inpatient speech therapy is part of an inpatient hospital service/stay Prior Authorization: Required	$25 copay Nothing during covered inpatient admission See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	**High**
Hearing Testing Hearing exams and testing for adults and children; copays do not contribute to the out-of-pocket maximum. Preventive screening for hearing loss in all newborns by one month of age is covered in full; enrolled in early treatment if identified as hard of hearing by age six months. Prior Authorization: Required	$25 copay
Hearing aids (Hearing Assistive Devices or Supplies) - Up to $1,000; member is responsible for excess charges. Hearing aids or ear molds; $1,000 maximum benefit One device per ear, every 36 months. Includes coverage for children under 18 with hearing loss. Coverage is limited to the types and models of hearing aids provided by WHA's hearing aid vendor.	Up to $1,000; member is responsible for excess charges.
Not covered: *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High**
• One pair of eyeglasses or contact lenses to correct impairment directly caused by accidental ocular injury or intraocular surgery (such as cataracts) • Annual eye refractions Note: *See Preventive care, children* for eye exams for children.	$25 copay Nothing for routine annual vision testing and examination.
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**High**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$25 copay
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (except for surgical treatment).*	*All charges*
Orthopedic and prosthetic devices	**High**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Implanted hearing-related devices, such as bone anchored hearing aids and cochlear implants	$25 copay

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**High**
• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. • Prescription support stockings. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical and anesthesia services. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services. Prior Authorization: Required	$25 copay
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Repair and replacement of Orthotics or Prosthetics when necessitated by the member's abuse, misuse or loss.* • *More than one device for the same body part.*	*All charges*
Durable medical equipment (DME)	**High**
Durable medical equipment may require prior authorization by your Primary Care Physician's affiliated medical group. Your Primary Care Physician will obtain the prior authorization. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Blood glucose monitors • Insulin pumps Prior Authorization: Required	20% of WHA's allowed amount
Breastfeeding pump, including any equipment required for pump functionality.	Nothing
Not covered: • *Repair and replacement of durable medical equipment when necessitated by the member's abuse, misuse or loss.* • *Any device not medical in nature (e.g. exercise equipment, whirlpool, spa), or more than one piece of equipment that serves the same function.*	*All charges*
Speech generating devices Prior Authorization: Required	$25 copay

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High**
Wigs for hair loss due to the treatment of cancer Prior Authorization: Required	Up to $750; member is responsible for excess charges
• Medical foods for children under medical necessity • Medical foods for adults under medical necessity Prior Authorization: Required	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Home health services	**High**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L. V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. Prior Authorization: Required	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Private duty nursing*	*All charges*
Chiropractic	**High**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Chiropractic services are provided by Landmark Healthplan. Visit www.westernhealth.com/FEHB to find a participating provider. A referral from your Primary Care Physician is not required to obtain chiropractic care. Note: Limited up to 20 visits per year; copayments do not contribute to the medical out-of-pocket maximum.	$15 copay This benefit does not contribute to the catastrophic out-of-pocket maximum.
Not covered: • *Maintenance and long term therapies.*	*All charges*
Alternative treatments	**High**
Acupuncture - by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner Acupuncture services are provided by Landmark Healthplan. Visit www.westernhealth.com/FEHB to find a participating provider. Note: Limited up to 20 visits per year.	$15 copay This benefit does not contribute to the catastrophic out-of-pocket maximum.
Not covered: • *All other forms of alternative medicine not otherwise listed in the policy.*	*All charges*

Benefit Description	You pay
Educational classes and programs	**High**
Coverage is provided for: • Tobacco cessation - Counseling and interventions, including over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. - The Quit For Life® Program is provided to Western Health Advantage members at no cost. Using a mix of medication and phone-based coaching, it can help you down the path to quit smoking and overcome physical, psychological and behavioral addictions to nicotine dependence. To learn more about this program visit westernhealth.com/FEHB.	Nothing
Diabetes self-management • Diabetic education	Nothing See section 5(h) Wellness and Other Special Features for more details.
Weight Management - Nutritional counseling with a network dietician or nutritionist for weight management is available for those struggling with obesity.	Nothing

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- 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.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**High**

A comprehensive range of services, such as:
• Operative procedures
• Treatment of fractures, including casting
• Routine pre- and post-operative care by the surgeon
• Correction of amblyopia and strabismus
• Endoscopy procedures
• Biopsy procedures
• Removal of tumors and cysts
• Correction of congenital anomalies (see Reconstructive surgery)
• Surgical treatment of severe obesity (bariatric surgery)
• Insertion of internal prosthetic devices. See 5(a) - Orthopedic and prosthetic devices for device coverage information.
• Treatment of burns
 	
Western Health Advantage considers the following bariatric surgical procedures medically appropriate when all of the general criteria and all of the criteria specific to the procedures are met. Here is a list of the general criteria:
• BMI of 35 or higher; or
• BMI of 30 – 34.9 with the following:
1. clinically serious condition related to obesity; and
  • Type 2 diabetes
  • Obesity hypoventilation
  • Obstructive sleep apnea
  • Nonalcoholic fatty liver disease
  • Pseudotumor cerebri
	Nothing
	
	See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
	
	See Section 5(a) diagnostic and treatment services for surgical services provided in an office setting.

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High**
• Polycystic ovary syndrome • Severe lower extremity osteoarthritis • Treatment-resistant hypertension 2. Failure of nonsurgical therapy • Adequate (6 months) healthcare provider supervised trial of non-operative weight loss in the 12 months immediately preceding the surgery request. The program should incorporate nutritional counseling and appropriate regular physical activity. Examples are: enrollment In Weight Watchers, Jenny Craig or work with a personal trainer at a gym alongside documented periodic follow-up visits with a dietician, physician, advanced care practitioner or rehab therapist. • Psychological Evaluation in the 3 months preceding date of request Note: For female surgical family planning procedures see Family Planning Section 5 (a). Note: For male surgical family planning procedures see Family Planning Section 5 (a). Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. Prior Authorization: Required	Nothing See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) diagnostic and treatment services for surgical services provided in an office setting.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Section 5(a) Foot care)*	*All charges*
Reconstructive surgery	**High**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as Lymphedemas - breast prostheses and surgical bras and replacements (see Section 5(a) *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain the hospital up to 48 hours after the procedure. Prior Authorization: Required	$25 copay (surgery consult and/or evaluation) See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
Not covered:	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High**
• *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 (See Section 5(d) Accidental injury).* • *Surgery for Sex-Trait Modification to treat gender dysphoria* Sex-Trait Modification: If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care. Our exception process is as follows: • Have a confirmed diagnosis of gender dysphoria by a licensed healthcare professional; and • Be actively engaged in an ongoing course of treatment at the time of the effective date of the exclusion (January 1, 2026); and • Have initiated either: - A surgical procedure or a course of staged surgical procedures; or - A continuous hormonal regimen that, if interrupted, would create a clinically significant risk to the member's health as determined by a licensed physician. The exception process will be applied on a case-by-case basis. In order to apply for an exception to the CL 2025-01-b exclusion of sex-trait medical interventions/ transgender services call our member services department at; 888-563-2250. You will also find more information on our member website at: westernhealth.com/FEHB. If you disagree with this information, please contact our member services department at; 888-563-2250 to speak to a representative, or you can email us at: appeal.grievance@westernhealth.com. *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*
Oral and maxillofacial surgery	**High**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. Prior Authorization: Required	$25 copay (surgery consult and/or evaluation) See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone).*	*All charges*

Benefit Description	You pay
Organ/tissue transplants	**High**
These **solid organ and tissue transplants** are covered and are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	$25 copay (surgical evaluation/ consultation) See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) Prior Authorization: Required	
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia)	$25 copay (surgery consult and/or evaluation) See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High**
- Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Aggressive non-Hodgkin lymphomas - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	$25 copay (surgery consult and/or evaluation) See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
Prior Authorization: Required **Mini-transplants performed in a clinical trial setting** (nonmyeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)	$25 copay (surgery consult and/or evaluation) See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High**
- Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma Prior Authorization: Required	$25 copay (surgery consult and/or evaluation) See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. 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. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia	$25 copay (surgery consult and/or evaluation) See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High**
• Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Colon cancer • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Myelodysplasia/Myelodysplastic Syndromes • Myeloproliferative disorders (MSDs) • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis Prior Authorization: Required	$25 copay (surgery consult and/or evaluation) See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
National Transplant Program (NTP) Note: We cover related medical and hospital expenses of the donor when we cover the recipient. 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. Prior Authorization: Required	$25 copay (surgery consult and/or evaluation) See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.). See Section 5(a) for surgical services provided in an office setting.
Not covered:	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High**
• *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High**
Professional services provided in – • Hospital (inpatient)	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Professional services provided in- • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Note: When the calendar year deductible does not apply we indicate - "Deductible does not apply"	
Inpatient hospital	**High**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: Western Health Advantage covers semi-private room and board and if only when medically necessary a private room. Prior Authorization: Required	$500 copay per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home Prior Authorization: Required	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center	**High**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Prior Authorization: Required	$100 copay
Extended care benefits/Skilled nursing care facility benefits	**High**
Extended care benefit/Skilled nursing care facility benefits: Covered when medically necessary and arranged by a primary care physician up to 100 days per calendar year. All necessary services are covered, including: • Semi-private room and board • Drugs and prescribed ancillary service Prior Authorization: Required	$500 copay per admission
Not covered: *Custodial care*	*All charges*
Hospice care	**High**
Hospice Care • Home-based hospice - Skilled nursing services - Medical social services; - Home health aide and housekeeping services - Pain Management - Services for companionship support, emotional support and caregiver relief - Short-term inpatient care including respite care for pain control and acute and chronic symptom management - Durable medical equipment - Counseling and bereavement services Prior Authorization: Required	Nothing
Not covered: • *Independent nursing, homemaker services*	*All charges*

Benefit Description	You pay
Ambulance	**High**
Ambulance • Local professional ambulance service when medically appropriate Prior Authorization is required for non-emergent ambulance transportation.	Nothing

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

Emergencies within our service area:

If you are experiencing a life-threatening emergency or condition, call 911 immediately or go directly to the nearest hospital emergency room. Call your Primary Care Physician so they can alert the emergency room that you are on your way. If you are unable to contact your Primary Care Physician, be sure to tell the emergency room personnel that you are a Western Health Advantage member so they can contact us at 888-563-2250.

If you are hospitalized at a non-Western Health Advantage participating facility, we must be notified within 24 hours or as soon as possible. This telephone call is extremely important. If you are unable to make the call, have someone else make it for you, such as a family member, friend, or hospital staff member. We will work with the hospital and physicians coordinating your care, make appropriate payment provisions, and if possible, arrange for your transfer back to a participating hospital.

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

Contact your Primary Care Physician for all follow-up care. If your health problem requires a specialist, your Primary Care Physician will refer you to an appropriate participating provider.

Emergencies outside our service area:

If you are outside Western Health Advantage's service area and hospitalized because of an emergency, WHA covers those services. You must notify us within 24 hours or as soon as possible to avoid any billing issues. If you are unable to make the call, have someone else make it for you, such as a family member, friend or hospital staff member.

We will work with the hospital and physicians coordinating your care, make appropriate payment provisions, and if possible, arrange for your transfer back to a participating hospital.

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

Contact your Primary Care Physician for all follow-up care. If your health problem requires a specialist, your Primary Care Physician will refer you to an appropriate participating provider.

Benefit Description	You pay
Emergency within our service area	**High**
• Emergency care at a doctor's office • Emergency care at an Urgent Care Center • Emergency care as an outpatient at a hospital, including doctor's services Note: We waive the ER copay if you are admitted to the hospital.	$25 copay $35 copay $100 copay
Emergency outside our service area	**High**
• Emergency care at a doctor’s office • Emergency care at an Urgent Care Center • Emergency care as an outpatient at a hospital, including doctor's services Note: We waive the ER copay if you are admitted to the hospital.	$25 copay $35 copay $100 copay
Ambulance	**High**
Professional ambulance service when medically appropriate. Prior Authorization is required for non-emergent ambulance transportation. Note: See 5(c) for non-emergency service.	Nothing

Section 5(e). Behavioral Health and Substance Use Disorder 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 and with a plan provider unless otherwise authorized.
- 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.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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
Professional services	**High**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy Prior Authorization: Required	$25 copay
Diagnostics	**High**
• Outpatient diagnostic tests provided and billed by a licensed behavioral health and substance use disorder treatment practitioner	$25 copay
• Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Inpatient diagnostic tests provided and billed by a hospital or other covered facility Prior Authorization: Required	$500 copay

Benefit Description	You pay
Inpatient hospital or other covered facility	**High**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semi-private or intensive accommodations, general nursing care, meals and special diets, and other hospital services Note: Western Health Advantage contracts with U.S. Behavioral Health Plan, California d/b/a OptumHealth Behavioral Solutions of California ("USBHPC") to manage your mental health and substance use disorder benefits. If you need MHSUD treatment or have questions about your MHSUD benefits, please call USBHPC at 1-888-440-8225. Prior Authorization: Required	$500 copay
Outpatient hospital or other covered facility	**High**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment. Note: Western Health Advantage contracts with U.S. Behavioral Health Plan, California d/b/a OptumHealth Behavioral Solutions of California ("USBHPC") to manage your mental health and substance use disorder benefits. If you need MHSUD treatment or have questions about your MHSUD benefits, please call USBHPC at 1-888-440-8225. Prior Authorization: Required	Nothing See Section 5(c) for charges associated with the facility (i.e. inpatient or outpatient hospital, or surgical center, etc.).
Not covered: • *Court-ordered health care services and supplies when not medically necessary.*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- 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 exclusion for chemical treatments for Sex-Trait Modification for gender dysphoria only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). We do not exclude coverage for entire classes of pharmaceuticals, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a Western Health Advantage participating pharmacy or by mail for maintenance medications and specialty medications.
- We use a Preferred Drug List. You may view Western Health's Preferred Drug List online at www.westernhealth.com/FEHB or request a copy by calling our Member Services team at 888-563-2250.
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan doctor if they would otherwise be covered, determined medically necessary and prior authorized by the Plan. In some cases, the physician will need to prescribe an alternative formulary drug if an alternative is available that is equally effective. Visit www.westernhealth.com/FEHB for medications that require prior authorization or are excluded.
- **We have a managed 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 our 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. You can view this list on our website www.westernhealth.com/FEHB or call 888-563-2250 to request a Preferred Drug List.
- **There are dispensing limitations.**
  - Prescription drugs filled at participating retail pharmacy will be dispensed for up to a 30-day supply except for contraceptives, when allowed by law.
    - Participating retail pharmacies will allow up to a 90-day supply on maintenance medication. The retail pharmacy copay applies for each 30-day supply.
  - Prescriptions filled by mail order (home delivery) will be dispensed for up to a 100-day supply. Mail order is for the dispensing of maintenance medications your physician has prescribed for long-term use. Drugs requiring immediate use are not available via mail order.
  - Specialty medications will be dispensed for up to a 30-day supply and must be ordered through Optum Specialty Pharmacy (delivered to home or medical office, depending upon who administers the drug.
  - Controlled substance medications have limited refill capabilities by law.

- Some drugs are limited to a fixed number of doses per 30-day period.

- **A generic equivalent will be dispensed if it available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a FDA approved generic is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than a name-brand drug.
- **When you have to file a claim**. If you receive a prescription outside of the area or a situation arises where the pharmacy cannot process a prescription under the Plan, you will need to mail, fax or email the following information to Western Health Advantage for reimbursement:

  - A signed and dated summary/explanation detailing the situation.
  - Any supporting documentation from the provider who prescribed the medication.
  - Indicate the specific amount you are requesting to be reimbursed.
  - Proof of payment your contact information, including your Western Health Advantage member ID.
  - Upon receipt of the above information, you will be notified within 45 business days regarding the outcome of your claim.
    - Please note: Only services covered under your plan are eligible for reimbursement. Your applicable member cost share will determine the total amount you are reimbursed.

Benefit Description	You pay
Covered medications and supplies	**Basic**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetes supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see limits listed in the drug list) • Drugs to treat obesity will require a prior authorization Drug therapy for patients with obesity is established by the treating provider. Members should review their drug formulary for coverage information and any utilization management requirements. *Visit westernhealth.com/FEHB. for a list of obesity treatment medications on the Plan's Preferred Drug List.* Note: *Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco and nicotine dependence are covered under the Tobacco cessation benefit. (See Section 5(a), Educational classes and programs, page 48.*	**For drugs filled at Plan Retail Pharmacy - 30-day supply** $15 for Tier 1 - Preferred Generics and certain Preferred Brands $50 for Tier 2 - Preferred Brands name and certain Non-Preferred Generics $75 for Tier 3 - Non-Preferred (generic or brands) $250 for Tier 4 - Specialty Drugs (Only available at Optum Specialty Pharmacy) (Prior authorization required for all specialty drugs) **Mail Order (home delivery) 100-day supply** $30 per for Tier 1 - Preferred Generics and certain Preferred Brands $100 for Tier 2 - Preferred Brands name and certain Non-Preferred Generics $150 for Tier 3 - Non-Preferred (generic or brands)

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Basic**
	Note: If there is no generic equivalent available, you will still have to pay the brand name copay. Participating retail pharmacies allow up to a 90-day supply on maintenance medication. The retail pharmacy copay applies for each 30-day supply. Specialty medication must be ordered through Optum Specialty Pharmacy (delivered to home or medical office, depending on who administers the medication.
Contraceptive drugs and devices as listed in the ACA/HRSA site. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-Supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • If you don't agree with a decision about an excluded medication, you or your authorized representative and your doctor can ask for a coverage request by call the number on your member ID. Western Health Advantage Member Service Representatives can help guide your further. If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Notes: • For additional Family Planning benefits see Section 5(a) • Birth control pills are no-cost for Generic only. • Member pays brand copay if the prescribing physician specifies "dispense as written" (DAW).	Nothing
Drugs to treat sexual dysfunction are limited to Viagra and Cialis. Contact the Plan at 888-563-2250 for dose limits.	50% copay per unit or refill
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a Western Health Advantage participating pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Basic**
Not covered: • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications unless specifically indicated elsewhere* • *Drugs prescribed by a provider who is not acting within their scope of licensure.* • *New to market Drugs. Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on Our Drug List.* • *New to market biologics, biosimilars and professionally administered drugs. Biologics, biosimilars and professionally administered drugs recently approved by the FDA (including approval for a new indication) will not be covered until they are reviewed and approved for coverage by Us.* • *If you fail to provide your prescription coverage information to the pharmacy, you will be responsible for any amount above what We would have paid for your prescription under this policy.* • *Products that are duplicative to, or are in the same class and category as, products on Our Drug list.* • *Drugs, supplies, biologics and biosimilars that have not been approved by the U.S. Food and Drug Administration (FDA).* • *Professionally administered drugs that do not meet both of the following requirements: (a) administered in conjunction with a covered benefit and (b) administered by a physician acting within the scope of the provider's license.* • *Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.* • *Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.* • Drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria Sex-Trait Modification: If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care. Our exception process is as follows: • Have a confirmed diagnosis of gender dysphoria by a licensed healthcare professional; and • Be actively engaged in an ongoing course of treatment at the time of the effective date of the exclusion (January 1, 2026); and • Have initiated either: - A surgical procedure or a course of staged surgical procedures; or - A continuous hormonal regimen that, if interrupted, would create a clinically significant risk to the member's health as determined by a licensed physician.	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Basic**
The exception process will be applied on a case-by-case basis. In order to apply for an exception to the CL 2025-01-b exclusion of sex-trait medical interventions/ transgender services call our member services department at; 888-563-2250. You will also find more information on our member website at: westernhealth.com/FEHB. If you disagree with this information, please contact our member services department at; 888-563-2250 to speak to a representative, or you can email us at: appeal.grievance@westernhealth.com. *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*
Preventive Care Medications	**Basic**
Medications to promote better health as recommended by ACA The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a healthcare professional and filled at a network pharmacy. • Select preventive medications from the drug formulary within the following categories: Antihypertensives, Antihyperlipidemics, Antidiabetics, Anticoagulants, Antiplatelets, Osteoporosis, Antiasthmatics/Bronchodilators and mental health medications • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age (400 & 800 mcg) • Liquid iron supplements for children age 0-1 year • Prescription strength vitamin D supplements for members age 65 or older (400 • Pre-natal vitamins for pregnant individuals • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 years Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs*, except for fertility medications under Western Health Advantage's Family & Diversity Support services • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them; except as required by ACA (except for Vitamin D for adults age 65 and older)* • *Nonprescription medications unless specifically indicated elsewhere*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be 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.
- 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.

Benefit Desription	You Pay
Accidental injury benefit	**High Option**
We cover non-dental surgical and hospitalization procedures required due to facial fractures, tumors or congenital defects, such as cleft lip or cleft palate.	$25 copay at the PCP's office $25 copay at the specialist's office $100 copay at the emergency room
Not covered: *Items or services in connection with the care, treatment, filling, removal, replacement, or artificial restoration of the teeth or structures directly supporting the teeth.* *Treatment of dental abscesses, braces, bridges, dental plates, dental prostheses and dental orthoses, including anesthetic agents or drugs used for the purpose of dental care.*	All charges

Section 5(h) Wellness and Other Special Features

Feature	Description
24/7 Access to manage your health Plan benefits	Setting up and accessing your MyWHA account at westernhealth.com/FEHB gives you access to your personal account through this secure, member-only website. Log on to find a wealth of resources that will help you get the most from your health Plan. After creating your MyWHA account, you will be able to: • Print a temporary or request a replacement member ID card • Change your Primary Care Physician • Review your plan documents • Connect to your pharmacy benefits • Review your accrual toward out-of-pocket expenses
Chronic Condition Management	Western Health Advantage members living with a chronic illness have access to helpful resources and a care manager to help them manage their condition. Members living with the following chronic illnesses may be eligible for personalized support to manage their health and related risk factors: • Asthma • Coronary artery disease (CAD) • Chronic obstructive pulmonary disease (COPD) • Congestive health failure (CHF) • Diabetes (type 1 and type 2)
Diabetes Prevention	Western Health Advantage's diabetes prevention program **Real Appeal** helps our members take small, doable steps that lead to big results. Make small changes over time to gradually shift to a happier, healthier lifestyle. Life changing results with support and resources along the way.
Diabetes Reversal	**Virta Health** is a telehealth program that helps participants lower blood sugar and A1C, reduce or eliminate diabetes medications, and lose weight. This program includes a • Medical coaching team • Weight scale • Glucose meter • Ketone strips • Lancets and swabs Visit westernhealth.com/FEHB for more information.
Health Classes and Support Groups	Access instructor-led health education programs sponsored by Western Health Advantage's network medical groups. Classes and support groups include: • Nutrition • Breastfeeding and lactation counseling • Pregnancy and childbirth • Smoking cessation Unless otherwise noted, most classes are free. Learn more at westernhealth.com/FEHB

Feature - continued on next page

Feature (cont.)	Description
Hypertension Management	Western Health Advantage members over age 18 with high blood pressure (also known as hypertension), **Livongo** offers advanced tools to help manage high blood pressure, such as a connected blood pressure monitor sent directly to your home, real-time advice on your readings, and personal coaching and support. For more information visit westernhealth.com/FEHB.
Nurse Advice Line	Nurse Advice is WHA's confidential phone line staffed by registered nurses 24/7 offering immediate, expert guidance and assistance whenever a health concern arises, day or night. Visit westernhealth.com/FEHB for more information.
Pain Management	Managing pain is easer through **Kaia Health**, an innovative digital physical therapy (PT) program and app to help with back, neck, and knee pain. When in-person therapy or travel to appointments is not an option, AI-driven technology uses your smart device to deliver coaching and feedback, function assessment, and warm-ups for virtual therapy that is accessible anytime or anywhere. Visit westernhealth.com/FEHB.
Pregnancy and Postpartum Support	In addition to Western Health's health pregnancy benefits and resources, we have partnered with Maven Maternity to provide additional virtual support from coaches and specialists, along with educational materials for expectant parent/partner. Learn about how the Maven Maternity program provides comprehensive support through pregnancy, postpartum and potential miscarriage at westernhealth.com/FEHB.
Smoking Cessation	**Quit for Life** is a program for Western Health members looking to overcome tobacco and nicotine addiction dependency. The program offers personal coaching by phone, chat, or text; online group sessions; and nicotine replacement therapy. Visit westernhealth.com/FEHB.

Non-FEHB Benefits Available to Plan Members

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 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, 888-563-2250 or visit their website at westernhealth.com/FEHB.

Fitness Discounts	As a Western Health Advantage member, you have access to fitness discounts through our following partnerships: **Active and Fit Direct®** - As a Western Health member you get access to more than 12,700+ Active standard" network gyms when you purchase a membership. You can visit any of the participating fitness centers in the Active&Fit Direct network. Additional discounts are available with the purchase of a premium network gym membership. **ChooseHealthy®** - provides you with reduced rates on a variety of fitness, health and wellness products. This includes activity trackers, online tools to help manage your health, workout apparel, and exercise equipment. **Fitness Center Partner Discounts** – Western Health partners with locally owned gyms and fitness centers to offer additional discounts. Visit westernhealth.com/FEHB for information to find a participating fitness center in your area.
Global Emergency Assistance	Anytime Western Health Advantage members travel 100 miles or more away from home and for less than 90 days, even in a foreign country, they benefit from 24/7 support from Assist America. Assist America offers valuable assistance services in the event you face an emergency while traveling such as:

	• Medical consultation and referrals • Care of a minor child • Lost luggage or document assistance Visit westernhealth.com/FEHB
Online Healthy Recipe Library	Browse hundreds of healthy recipes from reputable health organizations supporting heart health and other health conditions. Reap the benefits of a nutritionally sound lifestyle improving emotional well-being, weight management, and longevity. Visit westernhealth.com/FEHB.
Personal Health Assessment	The online health management tool is where you complete an annual personal health assessment (PHA). You will receive a health score card that connects you with resources and information to create an action plan and improve your health/scorecard. Visit westernhealth.com/FEHB.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. A**lthough we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition**. For information on obtaining prior approval for specific services, such as transplants, see Section 3 When you need prior Plan approval for certain services.

We do not cover the following:

- Any services or supplies obtained before the Member's effective date of coverage or after the Member's coverage has terminated.
- Any service provided without Prior Authorization if the service requires a PCP referral or Prior Authorization as explained in this Brochure.
- Cosmetic services and supplies, except for prosthetic devices incidental to a mastectomy or laryngectomy or reconstructive surgery, which is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease; to do either of the following: (A) to improve function; (B) to create a normal appearance, to the extent possible.
- Non-emergent medical and psychiatric transport or ambulance care inside or outside the Service Area, except with Prior Authorization.
- Vision therapy, eyeglasses, contact lenses and surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses. (This exception does not include intraocular lenses in connection with cataract removal.)
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency services/accidents).
- Exercise programs.
- Long-term or maintenance therapy.
- 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: 1) an individual suffers from a physical disorder, physical injury, or physical illness that would place the individual in danger of death unless an abortion is performed; 2) the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services required for administrative examinations such as employment, licensing, insurance, adoption, or participation in athletics.
- Services or supplies for, or in connection with, a non-covered procedure or service; a denied referral or prior authorization; or a denied admission.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services or supplies we are prohibited from covering under the Federal law.
- Any benefits or services required solely for your employment are not covered by this plan.
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include "gender transition" services), other than mid-treatment exceptions, see Section 3. How You Get Care.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, 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.

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 HIPAAcomplaint electronic claims for you. Provider must file on the form CMS-1500, Health Insurance Claim Form. In cases where a paper claim must be used, the provider must file on the form CMS-1500, Health Insurance Claim Form. For claims questions and assistance, contact us at 888-563-2250, or at our website at westernhealth.com.

When you must file a claim – such as for services you received outside the Plan's service area – the Claim Reimbursement Form is available by logging into mywha.org – choose the Request Reimbursement under MyTOOLs. You can submit your claim 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, date of birth, address, phone number and ID number
- Name and address of the provider 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)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Western Health Advantage, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833

Attention: Claims Department

Prescription drugs

If you receive prescription drugs from a non-network pharmacy in an emergency or urgent situation, please submit your receipts along with a claim for reimbursement. For claims questions and assistance, or to request a prescription drug claim form call us at 844.568.4150.

Deadline for filing your claim

If you receive services from a Health Care Provider that require you to submit the claim to us for reimbursement, you must obtain an itemized bill and submit it to:

Western Health Advantage,

2349 Gateway Oaks Drive, Suite 100,

Sacramento, CA 95833

Attention: Claims Department

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.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-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 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.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

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, we will permit a healthcare professional with knowledge of your medical condition 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.

Notice Requirements

If you live in a country where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 If you disagree with our pre-service claim decision, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

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. To make your request, please contact our Appeals and Grievance Department by writing to Western Health Advantage, Attn: Appeals & Grievances - 2349 Gateway Oaks, Suite 100, Sacramento, CA 95833 or calling 888-563-2250.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Attention: Appeals and Grievances Western Health Advantage, 2349 Gateway Oaks, Suite 100, Sacramento, CA 95833; 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 for member), 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. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information 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.

3

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

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

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 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 healthcare 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.

4

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 or notify you of the status of OMP's review within 60 days. There are no other administrative appeals.

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

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

You may not file a lawsuit 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 888-563-2250. We will expedite 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 FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under the Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9 Coordinating Benefits With Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health Plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary 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' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.westernhealth.com/FEHB.

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 processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

TRICARE and CHAMPVA

TRICARE is the healthcare 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 or employing 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

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered 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.

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 or employing 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

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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.gov or by phone at 1-877-888-3337, (TTY 1-877-889-5680), 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

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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 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.
- 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.

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.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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 888-563-2250 or see our website at www.westernhealth.com/FEHB.

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

- Medical services and supplies provided by physicians and other healthcare professionals.

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

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Deductible
You pay without Medicare- (High Option): N/A - No deductible
You pay with Medicare Part B - (High Option): N/A - No deductible

Out-of-Pocket Maximum
You pay without Medicare- (High Option): $2,500 Self Only/$5,000 Self Plus One/$5,000 Self and Family
You pay with Medicare Part B - (High Option): $2,500 Self Only/$5,000 Self Plus One/$5,000 Self and Family

Part B Premium Reimbursement Offered
You pay without Medicare- (High Option): N/A
You pay with Medicare Part B - (High Option): N/A

Benefit Description: Primary Care Provider
High Option You pay without Medicare: $25 copay
High Option You pay with Medicare Part B: $25 copay

Benefit Description: Specialist
High Option You pay without Medicare: $25 copay
High Option You pay with Medicare Part B: $25 copay

Benefit Description: Inpatient Hospital
High Option You pay without Medicare: $500 copay
High Option You pay with Medicare Part B: $500 copay

Benefit Description: Outpatient Hospital
High Option You pay without Medicare: $100 copay

High Option You pay with Medicare Part B: $100 copay

Incentives Offered
You pay without Medicare- (High Option): N/A
You pay with Medicare Part B - (High Option): N/A

You can find more information about how our plan coordinates benefits with Medicare by calling our Customer Care Center at 888-563-2250 or at www.westernhealth.com/FEHB.

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 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.

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.)**

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

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

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

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

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is considered in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded, conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

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 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.
- 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.
- 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.

Coinsurance

See Section 4, Your Costs for Covered Services, page 26.

Copayment

See Section 4, Your Costs for Covered Services, page 26.

Cost-Sharing

See Section 4, Your Costs for Covered Services, page 26.

Covered services

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

Custodial Care

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

Experimental or Investigational Service

Experimental or investigational procedures means services, tests, treatments, supplies, devices or drugs which Western Health determines are not accepted as either standard medical practice by informed medical professionals in the United States at the time the services, tests, treatments, supplies, devices or drugs are rendered, or as safe and effective in treating or diagnosing the condition for which their use is proposed, or are not likely to be more beneficial for the treatment of a condition or illness than the available standard.

Group Health Coverage

Health coverage provided through a group policy, such as the FEHB program.

Healthcare Professional

A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

Hospice

Hospice care means services provided by participating providers to members who are certified in writing by a participating physician to be terminally ill.

Medical necessity

Medically necessary means that which Western Health determines:

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

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

For MHSUD Services, "Medically Necessary" means a service or product addressing the specific needs of the particular Member, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following as determined by USBHPC:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of WHA or USBHPC or Members, or for the convenience of the patient, treating physician, or other health care provider.

"Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and MHSUD treatment.

Plan allowance

Plan allowance is the amount we use to determine our payment and your co-insurance for covered services.

We determine our Plan allowance as follows: Covered charges will be paid based on the contract agreement between the Plan and the Plan provider (subject to any coinsurance and copayment provisions outlined in this Certificate). If there is a difference between our contracted amount and the amount that the provider bills us, you will not be responsible for that amount.

You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

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.
Primary Care Provider (PCP)	Provider can be a family practitioner, internist or pediatrician.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise Bill	An unexpected bill you receive for • emergency care – when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for • air ambulance services furnished by nonparticipating providers of air ambulance services.
Us/We	Us and We refer to Western Health Advantage.
You	You refers to the enrollee and each covered family member.
Urgent Care Claims	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law. 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 determine whether or not 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 Care Center at 888-563-2250. 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.

Index

Summary of Benefits for the High Option

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.westernhealth.com/FEHB.
- 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.
- There is no calendar year deductible for this Plan.

High Option Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: $25 primary care; $25 specialist	32
Services provided by a hospital: • Inpatient	$500 per admission copay	57
Services provided by a hospital: • Outpatient	$100 copay	58
Emergency benefits: • In-area	$100 copay (waived if admitted to the hospital)	61
Emergency benefits: • Out-of-Area	$100 copay (waived if admitted to the hospital)	61
Mental health and substance use disorder treatment:	Regular cost-sharing	62
Prescription drugs: • Retail Pharmacy	• Tier 1: Preferred Generics and certain Preferred Brands - $15 copay • Tier 2: Preferred Brands and certain Non-Preferred Generics - $50 copay • Tier 3: Non-Preferred Generics and Brands - $75 copay • Tier 4: Specialty Drugs (Only available at Optum Specialty Pharmacy) (Prior authorization required for all specialty drugs) - $250 copay (limited 30-day supply)	65
Prescription drugs: • Mail order	Mail Order (Tiers 1-3, 100-day supply, Tier 4, Specialty limited to a 30-day supply.) • Tier 1: Preferred Generic and certain Preferred Brands - $30 copay • Tier 2: Preferred Brans and certain Non-Preferred Generics - $100 copay • Tier 3: Non-Preferred Generics and Brands - $150 copay • Tier 4: Specialty Drugs) (prior authorization required) - $250 copay	65

High Option Benefits	You Pay	Page
Dental care:	No benefit.	69
Vision care:	No benefit.	45
Special Features:	See Section 5(h) for more information.	70
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $2,500 for Self Only or $5,000 for Self Plus one or $5,000 for Self and Family enrollment. Some costs do not count toward this protection.	26

Notes

Notes

2026 Rate Information for Western Health Advantage

To compare your FEHB health Plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health Plan options please go to www.opm.gov/FEHBpremiums **or** www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
California					
High Option Self Only	W51	$324.76	$120.95	$703.65	$262.06
High Option Self Plus One	W53	$711.17	$269.39	$1,540.87	$583.68
High Option Self and Family	W52	$778.03	$291.67	$1,685.73	$631.95