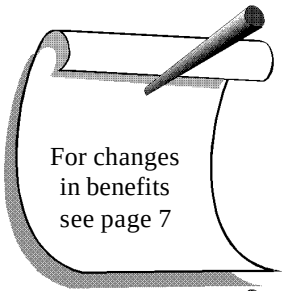
Texas Health Choice

www.texashealthchoice.com

2001

A Health Maintenance Organization



Serving: Dallas and Fort Worth Areas

Enrollment in this Plan is limited; see page 5 for requirements.

Enrollment codes for this Plan:

UK1 Self Only
UK2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees
Health Benefits Program

RI 73-063

Table of Contents

Introduction

Texas Health Choice, L.C.
9330 Amberton Parkway
Dallas, Texas 75343

This brochure describes the benefits you can receive from Texas Health Choice under our contract (CS1894) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means *Texas Health Choice.*

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

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

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

How we pay providers

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

Texas Health Choice, L.C., offers comprehensive health care coverage on a pre-paid basis at contracted facilities conveniently located throughout our service areas and through referral specialists, hospitals, and other providers in the community. All care should be received from these contracted providers except in medical emergencies.

As a mixed model plan, Texas Health Choice, L.C. contracts with doctors who practice under an Independent Practice Association (IPA), in medical centers or groups of physicians or with individual physicians to provide your care. Medical care is provided through doctors, nurse practitioners and other skilled medical personnel working as medical teams for consultation and treatment. Other necessary medical services, such as physical therapy, laboratory and X-ray services are also available at Plan facilities. Hospital care is provided through the Plan at several local community hospitals.

You must choose a primary care doctor when you choose this Plan. The Texas Health Choice provider directory lists primary care providers with their locations, and phone numbers. (Primary care doctors generally include family practitioners, pediatricians, and internists.) The primary care doctor you select will determine which set of specialty physicians you may access. For example, if you select a primary care doctor affiliated with one of our contracted IPAs, you will only be able to access specialists affiliated with that IPA.

In addition to selecting a primary care doctor, we also request that female members over the age of 14 select an Obstetrician and Gynecologist at the same time they select a primary care doctor. Obstetrics and Gynecology doctors may be accessed directly without referral from a primary care provider ("PCP"). Your choice of an Obstetrician and Gynecologist is determined by your choice of a PCP.

If you have a chronic, disabling or life-threatening condition you may apply to our Medical Director to request a Non-PCP specialist to be your personal provider. You must meet certain conditions as specified by our Medical director in order for your request to be approved. For more information regarding an application, please contact our Member Services Department at 1-800- 466-8397.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. 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.

- Texas Health Choice has operated in Texas as a mixed model HMO for 5 years.

- We understand the importance of getting your questions answered. Whether you need an answer to a benefit question or have a concern about a claim, a complaint about services you have received or need help in selecting a provider, our friendly and professional Member Services representatives are ready to assist you. We are available Monday through Friday, from 8am to 5pm at 1-800- 466-8397.
- Your personal information is confidential. Each enrolled member of your family will receive an ID card with a personal health record number. We want you to know that Texas Health Choice only shares information with individuals or entities when necessary to coordinate your health care or administer your health benefits. We also require that our contracted providers take similar steps to ensure that your health care information remains confidential.
- In certain circumstances, it is necessary for you to get prior authorization before receiving services. In such cases, if you do not receive a prior authorization, Texas health Choice will not be financially responsible for your services.
- At times, services requested on your behalf by your provider may be denied. The decision to deny services requested, courses of treatment, and, or inpatient services is made by a physician. Denial of service or care is based upon medical necessity, benefit coverage, and your individual needs. Written notification of the denial will be sent to you, your PCP, and the provider who requested the service. You have the right to appeal these decisions.
- Texas Health Choice has entered into aggreements with Health Care providers to deliver medically necessary covered services to you in cooperation with our Quality Assurance and Utilization review programs. Our agreements contain compensation arrangements that include incentives for our providers to control the utilization of medically unnecessary services. These incentives include payment to the provider of fixed monthly amounts (capitation) to cover budgeted costs of certain health care services for you. Incentives may also include additional amounts if costs of referral services are less than budgeted or a reduction in payment if the costs of referral exceed budgeted amounts.
- Texas Health Choice also offers disease management programs to assist you with chronic conditions such as pediatric asthma, diabetes and congestive heart failure. These are comprehensive programs that usually include patient education classes, specialty clinics, or case management monitoring.
- Texas Health Choice offers numerous preventive health management programs to assist you with early detecting and prevention of serious illnesses. These programs promote services such as childhood immunizations, breast and cervical cancer screenings, or prenatal care.

If you want more information about us please call our Member Services department at 1-800- 466-8397, or write to Texas Health Choice. You may also contact us by fax at 702-242-9350 or visit our website at www.texashealthchoice.com

Service Area

To enroll with us, you must live or work in our service area. This is where our providers practice.

Our service area is comprised of the following full counties in the **Dallas/Ft. Worth area**:

Collin, Dallas, Denton, Ellis, Hood, Hunt, Johnson, Kaufman, Parker, Rockwall, Tarrant, and Wise.

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. We will not pay for any other health care services.

If you or a covered family member travels frequently or lives away from home part of the year, you should be aware that benefits for care outside the service area are restricted to emergency care.

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

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our *"plan network"*, will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed *"shorter day or visit limitations"* on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling Member Services at 1-800-466-8397 or checking our website at www.texashealthchoice.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
    - •• Speak up if you have questions or concerns.
    - •• Keep a list of all the medicines you take.
    - •• Make sure you get the results of any test or procedure.
    - •• Talk with your doctor and health care team about your options if you need hospital care.
    - •• Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-postal premium will increase by 16.8% for self only and 16.9% for self and family.
- Rehabilitation Services for speech, physical or occupational therapy do not have visit limitations.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your 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 1-800-466-8397.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service areas that we contract with to provide covered services to our members. We credential Plan providers according to national standards. Our networks consist of physicians, physician assistants and nurse practioners who work together to provide or coordinate your medical care. You must choose a Primary Care Provider (PCP) who will provide the majority of your health care services. We list Plan providers in the provider directory, which we update periodically. The list is also on our website or you can contact Member Services at 1-800-466-8397.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do

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

- **Primary care**

Your PCP will provide most of your health care, or give you a referral to see a specialist. PCPs practice in one of the primary care specialties of adult medicine, family practice, internal medicine, or pediatrics. Each covered member of your family may select his/her own PCP. Your PCP is also part of a network or association of health care professionals who work together to provide a full range of health care services. That means that when you choose your PCP, you are also choosing a network, and in most cases are not allowed to receive covered services from any physician or provider who is not part of your PCPs network. All of your care will be provided by or arranged for within the network to which your PCP belongs, so make sure your PCPs network includes hospitals and specialists that you prefer. If you want to change PCPs or if your PCP leaves the Plan, call us. We will help you select a new one.

· **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see a specialist without a referral in the following circumstances:

- Your obstetrician/Gynecologist, for annual well-woman care.
- A specialist approved by our medical director to act as your PCP if you have a chronic, disabling or life-threatening illness.

Here are 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 PCP will work with the plan to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your PCP will use our criteria when creating your treatment plan and must request approval from a Texas Health Choice Medical Director.
- If you are seeing a specialist when you enroll in our Plan, talk to your PCP. Your PCP will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your PCP, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
    - terminate our contract with your specialist for other than cause; or
    - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
    - reduce our service area and you enroll in another FEHB Plan, you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the program contact your new plan.

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

· **Hospital care**

Your Plan PCP 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 in the hospital when your enrollment in our Plan begins, call our customer service department immediately at1-800-466-8397. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your PCP has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process Prior Authorization. Your physician must obtain Prior authorization for the following services: Some Services that require Prior Authorization include but are not limited to:

- Non-emergency Inpatient admissions and extensions of stay in a Hospital, Skilled Nursing Facility or Hospice.
- Outpatient surgery provided in any setting, including technical and professional services.
- Diagnostic and Therapeutic services
- All specialist visits or consultations.
- Prosthetic and Orthotic Devices
- Courses of treatment, including but not limited to Allergy testing or treatment; angioplasty; Home Health Care; physiotherapy; manual manipulation and rehabilitation therapies.

It is your physician's responsibility to obtain Prior Authorization for any covered service.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

· **Copayments**	A copayment is a fixed amount of money you pay to the provider when you receive services. Example: When you see your PCP you pay a copayment of $10 per office visit.
· **Deductible**	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. We do not have a deductible.
· **Coinsurance**	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our plan, you pay 50% of our allowance for infertility services and durable medical equipment.

Your out-of-pocket maximum For Copayments and Coinsurance

After your copayments total $600.00 per person or $1,200.00 per family enrollment in any calendar year, you do not have to pay any more for covered services. 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:

- Prescription drug copayments do not apply toward the Copayment maximum
- Any amounts you have paid for services that are not covered.

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

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 61 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsection. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-466-8397or at our website at www.texashealthchoice.com

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

IMPORTANT

Here are some important things to 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.
- We have 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.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per office visit
Professional services of physicians • In an urgent care center	Nothing ($25 facility charge includes physician charges)
• During a hospital stay	Nothing
• In a skilled nursing facility	Nothing
• Initial examination of a newborn child covered under a family enrollment	$10 per office visit
• Office medical consultations	$10 per office visit
• Second surgical opinion	$10 per office visit
At home	Nothing

Diagnostic and treatment services	You pay
Not covered: Services for which coverage is not specifically provided, complications arising from non-covered services, or services that are not medically necessary, except for medical emergency services. Services not provided, directed, and/or Prior authorized by your PCP, except for medical emergency services. Elective or non-emergency services performed outside the service area. Travel and accommodations, whether or not recommended or prescribed by a Provider. Sports medicine treatment plans intended to primarily improve athletic performance. The health plan is not financially liable for any missed or broken appointment fees charged to you by a provider.	*All charges*
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	
Routine screenings, such as • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including •• Fecal occult blood test	$10 per office visit
•• Sigmoidoscopy, screening – every five years starting at age 50	$10 per visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per visit
Routine PAP test Note: The office visit is covered if PAP test is received on the same day; see *Diagnostic and Treatment Services*, above.	$10 per visit

Preventive care, adult *(Continued)*	**You pay**
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	*Nothing*
Not covered: Third-party physical exams for employment, licensing, insurance, school, camp, sports or adoption purposes. Immunizations related to foreign travel.	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per office visit
Preventive care, children	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Examinations, such as: •• Eye exams through age 17 to determine the need for vision correction. •• Ear exams through age 17 to determine the need for hearing correction •• Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22) • Newborn hearing screening and necessary follow-up care.	$10 per office visit $10 per office visit $10 per office visit.

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • Routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
• Voluntary sterilization • Vasectomy • Tubal Ligation • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	 $75 per procedure; $200 per procedure Insertion and/or implantation fees are determined by where services take place (office visit, inpatient). $10 per office visit See Section 5(f) for Prescription Drug coverage.
Not covered: *reversal of voluntary surgical sterilization,* *genetic counseling,* *Drugs related to non-covered infertility treatments*	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• *intravaginal insemination (IVI)* •• *intracervical insemination (ICI)* •• *intrauterine insemination (IUI)* • Fertility drugs Note: Drugs used for covered infertility treatments are provided under the Prescription Drug benefit at 50% of the charge.	$10 per office visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization* •• *embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit Nothing if part of an office visit.
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 27. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We will only cover GHT when we preauthorize the treatment. Your provider will submit information that establishes that the GHT is medically necessary. Your provider must ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date the information is submitted. If GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. Drugs for GHT are covered under the Prescription Drug benefit at 50% of the charges.	$10 per office visit
Not covered: *Treatments that have not been prior authorized or are not medically necessary*	*All charges.*

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy— • 60 visits per condition for the services of each of the following: •• qualified physical therapists; •• speech therapists; and •• occupational therapists. • Cardiac Rehabilitation – Following a heart transplant, bypass surgery or a myocardial infarction is provided at a plan facility for up to 36 sessions Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. Medically necessary physical therapy, occupational therapy and speech therapy will not be denied, limited or terminated and will continue to be covered provided your condition improves and you continue to meet or exceed treatment goals. Treatment goals include recovery, restoration in function or improvement in the medical condition. Treatment goals for a physically disabled person as determined by your treating physician may include maintenance of functioning or prevention of or slowing of further deterioration.	$10 per office visit
Not covered: • *exercise programs, equipment or memberships* • *Hygiene equipment* • *Milieu therapy, biofeedback, behavior modification, sensitivity training, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolfing, residential treatment, vocational rehabilitation or wilderness programs.*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• Coverage is provided for hearing exams only when required to diagnose an injury or illness. • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (which include the written lens prescription for eyeglasses) may be obtained from plan providers.	$10 per office visit
• Lenses following cataract removal (initial device covered only)	20% of charges
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care)	$10 per office visit
• Annual eye refractions	$10 per office visit
Not covered: • *Eye exercises except if you have been diagnosed concurrently with amblyopia or strabismus.* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$10 per office visit
Podiatric appliances for the prevention of complications associated with Diabetes.	$10 per unit
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* • *Arch supports, support stockings, special shoe accessories, or corrective shoes unless they are an integral part of a lower body brace.*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose	$10 per office visit
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy	20% of charges
• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.	20% of charges
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* • *Comfort or convenience equipment* • *Disposable supplies or physician equipment, except for diabetic supplies and devices.* • *Devices not medical in nature such as air conditioning equipment, sauna baths and elevators.* • *Dental or maxillofacial prostheses, devices and appliances* • *Orthotics or prosthetics not used for customary activities of daily living;* • devices used primarily for sports activities.	*All charges.*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of medically necessary durable medical equipment Prior Authorized by Plan, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs; • crutches; • walkers; • Diabetic Equipment including insulin pumps, blood glucose monitors, and insulin infusion devices. Note: All Durable Medical Equipment must be medically necessary and Prior Authorized by the Health plan through your plan physician to be covered. Your physician will contact the Health plan for authorization.	20% of charges
Not covered: • *Deluxe equipment, except when such deluxe features are necessary for the effective treatment of your condition, or required in order to operate the equipment.* • *More than one piece of equipment serving essentially the same function, except for replacements as authorized by the health plan. Coverage for alternate or spare equipment is not provided.*	*All charges.*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications when prescribed by your plan physician, who will periodically review your program for continuing appropriateness and need.	Nothing

Home health services *(Continued)*	**You pay**
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation • Diabetes self-management ***For more information regarding these and other health and wellness programs and scheduled classes, please call 1-800- 720-7253; or call Member Services at 1-800-466-8397 for assistance.***	Materials fees are as follows: $25 per office visit $10 per office visit

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

IMPORTANT

Here are some important things to 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, coordinate or arrange your care.
- We have 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 amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital surgical center, etc.)
- Your PCP will coordinate any prior authorizations necessary.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Outpatient surgery performed in a physician's office	$10 per office visit
• Outpatient surgery performed in an ambulatory surgical center	Nothing
• Inpatient surgery	Nothing
Covered surgical procedures include:	
• Correction of congenital anomalies (see reconstructive surgery)	
• Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. Surgery for morbid obesity is covered only when authorized and only as a treatment of last resort.	
• Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
The internal prosthetic device must be medically necessary to restore bodily function and require a surgical incision (as opposed to an external prosthetic device). Examples: artificial knuckles and joints, pacemakers, insulin pump, defibrillator, penile implants.	
• Voluntary sterilization; •• Vasectomy •• Tubal Ligation	 $75 per procedure $200 per procedure
• Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a).	50% of charges
• Treatment of burns	Nothing – Inpatient or Outpatient $10 per office visit
Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done.	
Not covered: • *Reversal of voluntary sterilization*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes; craniofacial abnormalities of a member 18 years of age or younger due to trauma, tumors, infections, or diseases.	Nothing – Inpatient or Outpatient $10 per office visit

Reconstructive surgery *(Continued)*	**You pay**
• All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	See above.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Removal of teeth prior to chemotherapy or radiation treatment when it is determined in advance by our Medical director to be medically necessary and not a dental procedure.	Nothing – Inpatient or Outpatient $10 per office visit.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, or alveolar bone)* • *Shortening of the mandible or maxillae for cosmetic purposes*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Note: We cover medically necessary services and supplies related to donor procurement provided in conjunction with a covered transplant. Procurement means the obtaining of Medically necessary human organs or tissue for a covered transplant procedure as determined by the health plan and includes donor search, testing, removal, preservation and transportation of the donated organ or tissue. Procurement does not mean maintenance of a donor while the member is awaiting the transplant.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

Here are some important things to remember 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, coordinate 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 covered in Section 5(a) or (b).
- **Your physician will coordinate Prior authorization for your HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior authorization.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • 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	Nothing
Not covered: • *Custodial care* • *Non-covered facilities* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges*

Extended care benefits/skilled nursing care facility benefits	You pay
• Extended care benefit: The plan provides you with a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by your plan physician and approved by the Health plan. *All necessary services are covered, including: Bed, board and general nursing care.* • *Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your plan physician.*	Nothing
Not covered: custodial care	*All charges*
Hospice care	
In the event of a terminal illness, supportive and palliative care are provided for you in your home or a hospice facility. Services include:	
• Inpatient and outpatient family counseling	Nothing
• Outpatient bereavement counseling for each family member upon the death of the terminally ill patient.	$10 per visit with a calendar year maximum of 5 group therapy sessions or a maximum of $500 whichever is less.
• Respite care for each family member	Nothing up to a calendar year maximum of $1,000 for outpatient services and a maximum of $1,500 for inpatient services
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	$50 per trip

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have 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.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any Transportation charges covered in full.

Emergencies within our service area:

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

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

Plan pays...

Customary and reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay …

$50 per hospital emergency room visit (waived if admitted as an inpatient) or $25 per urgent care center visit for emergency services that are covered benefits of this Plan. $50 per ambulance trip, copayments as shown on page 43 for outpatient/inpatient surgical procedures and outpatient surgical facility visits and inpatient admissions, $25 per non-Plan doctor's office visit, and all charges for services which are not a covered benefit of this Plan.

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

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

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

Plan pays...

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay...

$50 per hospital emergency room visit (waived if admitted as an inpatient) or $25 per urgent care center visit for emergency services that are covered benefits of this Plan. $50 per ambulance trip, copayments as shown on page 43 for outpatient/inpatient surgical procedures and outpatient surgical facility visits and inpatient admissions, $25 per non-Plan doctor's office visit, and all charges for services which are not a covered benefit of this Plan.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per office visit $25 per visit $50 per visit, waived if admitted
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per visit $25 per visit $50 per visit, waived if admitted
Not covered: • *Elective care or non-emergency care* • Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area • Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	$50 per ambulance visit
Not covered: air ambulance if you could be safely transported by ground trasportation.	*All charges.*

Section 5 (e) Mental health and substance abuse benefits

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "party" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

When you get out approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	**You Pay**
Diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your conditions and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit

Mental health and substance abuse benefits – Continued on next page

Mental health and substance abuse benefits *(Continued)*	You Pay
• Diagnostic	$10 per office visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide on clinically appropriate treatment plan in favor of another.*	*All Charges*

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes. These include: Contacting our Behavioral Healthcare Options (BHO) to make arrangements to authorize medically necessary care. BHO may be contacted at (800) 873-2246. You may obtain more information about BHO by visiting their website at:

www.behavioralhealthcareoptions.com

Special transitional benefit

If your mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the changes in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. **You pay** a $6 copay per prescription unit or refill for generic drugs and a $12 copay for brand-name drugs when no generic equivalent is available.
- If you select a brand name drug when a generic equivalent is available and your doctor has not specified that only a brand name is sufficient, **you pay** the amount by which the cost of the brand name drug exceeds the cost of the generic equivalent, in addition to the $6 copayment.
- Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan'sPreferred drug list. Non-Preferred drugs will be covered when prescribed by a Plan doctor. You pay 50% of charges per prescription or refill.
- 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.

IMPORTANT

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

Who can write your prescription. Only a licensed plan physician can write your prescription, except in the case of an emergency or urgently needed prescription.

- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or you may use our mail order facility for a maintenance medication. Medications available through mail order are limited to those determined by the plan to be maintenance medications. The list of maintenance medications is maintained by the Plan at its sole discretion.
- **We use a formulary.** The Texas Health Choice Preferred list of drugs is a list of FDA approved Generic and Brand name covered drugs developed and maintained by the plan. The Preferred list is reviewed by physicians and pharmacists on a regular basis and may change throughout the year at the plan's sole discretion. Patient needs, scientific data, drug effectiveness, availability of drug alternatives currently on the Preferred list and cost are considerations in selecting medications for inclusion of drugs on Plan's Preferred list. Inclusion of drugs on the Preferred list does not guarantee that your provider will prescribe that medication. You may contact member Services at 1-800- 466-8397 to see if a particular drug is considered a Preferred drug. The plan will respond to a request no later than three business days from the date the request is received by phone or in writing.
- **These are the dispensing limitations.** A dispensing limitation is the quantity of a medication for which benefits are available for a single applicable copayment, or in the case of maintenance drugs, two copayments. The dispensing limitation may be 1) a predetermined period of time established by the Plan; or 2) a period of time that a specific medication is recommended by the FDA to be an appropriate course of treatment when prescribed in connection with a particular condition. Dispensing limitations may be less than but will not exceed a 30 day supply for drugs obtained at a plan pharmacy. Maintenance drugs dispensing limitations may be up to a 90 day supply, provided the medication is on the plan maintenance drug list. Prescriptions that exceed the dispensing limitations established by the plan will not be covered.
- A generic covered drug will be dispensed when available, subject to the prescribing provider's "Dispense as written" requirements.
- Drugs prescribed for a chronic, disabling or life-threatening illness are covered if:
  - The drug has been approved by the FDA for at least one indication; and

- The drug is recognized for treatment of the indication for which it was prescribed in:

  A compendium approved by the Insurance commissioner; or

  A substantially accepted peer-reviewed medical literature.

- 75% of a 30-day or 50% of a 10-day supply must elapse before a prescription can be refilled.
- **When you have to file a claim.** You normally won't have to submit a claim to us. If you need to file a claim, please send us all of the documents for your claim (including itemized billings) as soon as possible). You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time. Claim forms can be obtained by calling Member Services at 1-800- 466-8397. Only claims for emergency or urgently need services are eligible for reimbursement.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:	$ 6 per Generic Prescription $ 12 per Brand Name Prescription 50% of the charges for non-formulary prescriptions
• Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below.	
• Vitamins which require a prescription	
• Insulin	
• Disposable needles and syringes for the administration of covered medications	50% of charges
• Diabetic supplies including insulin syringes, needles, blood glucose measuring strips, and urine checking reagents	Nothing
• Drugs for sexual dysfunction Note: Sexual dysfunction drugs have specific dispensing limits and require prior authorization. Contact Member Services at 1-800-466-8397 for specific information.	
• Oral contraceptives	
• Contraceptive devices, injectable and internally implanted time-release drugs except Norplant.	Applicable generic or brand-name copay times the number of months the medication will be effective, not to exceed $200.
• Implanted contraceptive drugs such as Norplant are covered when other contraceptives are medically inappropriate or are contraindicated. There will be no refund of any portion of these copays if the implanted time-release medication is removed before the end of its expected life.	50% of the charges related to the device, implantation and removal.
Infertility drugs	50% of charges

Covered medications and supplies *(continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name. If you receive a brand name drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the brand name drug, you have to pay the difference in cost between the brand name drug and the generic.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nonprescription medicines and nutritional substances* • *Smoking cessation drugs and medications* • *Drugs obtained at a non-plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics.*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Medical Advice Line	For any of your health concerns, emergency or urgent care instructions, or to answer any health related questions please call: **In Dallas** (972) 479-1331 **In Fort Worth** (817) 338-9626 **Toll Free** 1-800-364-0964
Services for deaf and hearing impaired	TTY number for member Services assistance is 1-800-349-3538
Polypharmacy clinic	Texas Health Choice offers a medication management clinic in which registered pharmacists will meet with you to discuss and review your current medications. Both prescription and over-the-counter products will be reviewed for potential drug-drug interaction or other side effects that you may experience. This information will be helpful in discussing your medication treatment plan with your physician. Please call Member Services at 1-800-466-8397 for more information.
Centers of excellence for transplants	Texas Health Choice supports the use of centers of excellence for transplant patients. Should you or a member of your family need to utilize these services your physician will discuss all options available to you.
Travel benefit/ services overseas	Emergency services are covered anywhere in the world.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide, coordinate 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; 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.

IMPORTANT

Benefit Description	You pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Outpatient and inpatient surgery and inpatient admission co-payments for medical benefits also apply to these services.	$25 per emergency room visit $10 per office visit
Dental benefits	
The following dental services are covered when provided by participating Plan dentists. You are limited to two visits per calendar year for any combination of the five preventive and diagnostic services listed below.	
• Oral examinations	$10 per visit, plus $15 per emergency oral examination
• Dental prophylaxis (cleaning).	$10 per office visit, plus $10 per cleaning
• Topical application of fluoride	$10 per office visit
• Bitewing x-rays (no more than one set every six months)	$10 per office visit
• Full mouth series x-rays as reasonable and necessary for dental diagnosis and treatment	$10 per office visit
• Emergency dental services received outside the service area	*$25 per emergency visit*
What is not covered: • *Cosmetic dental services* • *Replacement of lost or stolen dentures; appliances or bridgework* • *Non-emergency care received from non-Plan dentist or non-emergency care received outside of the service area*	

Section 5 (i). 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 deductibles or out-of-pocket maximums.

If you are enrolled in this Plan through FEHBP, have Medicare Part A coverage and have purchased Part B coverage, you may also enroll in the Texas Health Choice Golden Choice program.

The Golden Choice plan provides all Medicare covered Part A and Part B benefits to the Medicare beneficiary, as well as some benefits not covered by Medicare. It is an arrangement between Medicare and this Plan in which Medicare pays a specific amount to this plan for each Medicare beneficiary who enrolls in the Plan.

Like your FEHBP enrollment in this Plan, you are required to obtain your services from this Plan's doctors and providers, except for emergencies and out-of-area urgent care. The rules regarding enrollment in Golden Choice are fully explained in the Plan's Evidence of Coverage. For a copy of these rules and or more information, please contact Member Services at 1-800 466-8397.

If you choose to enroll in Golden Choice, you will be responsible for paying the Medicare Part B premium. You must make an affirmative enrollment in Golden Choice. Information regarding enrollment and disenrollment rules may be found in the Evidence of Coverage for Golden Choice.

As a Texas Health Choice member you have access to discounted services at your local **Eye Masters** locations. These discounts include the following:	
• Frames, lenses, and lens options	35% discount
• Packaged collections	15% discount
• Contact lenses, discount is for materials only	20% discount on materials only
• Non-Rx Prescription sunglasses and accessories	15% discount
Note: Multiple eyeglass purchases – additional eyeglass purchases: 50% discount on non-package collections; 20% discount on packages such as Real Value, Knockabouts and SunMasters.	

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

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

and we agree, as discussed under *What Services Require Our Prior Approval* on page 10.

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are 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;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

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

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-466-8397. When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Texas Health Choice L.C.
Attention: Claims
P.O. Box 15645
Las, Vegas, Nevada 89114-5645

Prescription drugs

To submit claims for drugs, please contact Member Services at 1-800- 466-8397. We will assist you in completing a "Member Reimbursement Form" and help you process your claim with our Pharmacy Benefits Manager.

Submit your claims to:

ComCoTec
Attention Rx Claims
2505 South Finley Drive
Lombard, IL 60148

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for prior authorization:

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: **Texas Health Choice** **Customer Response and Resolution Department** **PO Box 15645** **Las Vegas, Nevada 89114-5645** (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.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or if applicable arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your medical provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write 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: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

The disputed claims process *(continued)*

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 provide a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

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

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

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

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

(a) We haven't responded yet to your initial request for care or pre-authorization/prior approval, then call us at 1-800-466-8397 and we will expedite our review; or

(b) We denied your initial request for care or prior authorization, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division III at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

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

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

· What is Medicare

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people may monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Managed Care plan is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

· The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care

(Primary payer chart begins on next page.)

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB		✓
Ask your employing office which of these applies to you.		
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee		✓

Claims process

You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at (702) 242-7300 or (800) 777-1840. You may also contact us by fax at (702) 242-9350 or visit our website at www.texashealthchoice.com.

We do not waive any out-of-pocket costs, when you have Medicare.

· Medicare Managed Care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare Managed Care plan: You may enroll in our Medicare Managed Care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

This Plan and another Plan's Medicare Managed Care Plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, or coinsurance.

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

· Enrollment in Medicare Part B

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.

Covered services

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

Custodial care

Custodial care means care that mainly provides room and board (meals) for you when you are physically or mentally disabled. Such care does not reduce your disability so that you may live outside a hospital or nursing home.

Experimental or investigational services

In order to keep pace with developments in new medical technology and to ensure that members have access to safe and effective care, Texas Health Choice has adopted a formal process to assess new and emerging medical discoveries before they are included in our member benefit package. This process includes the review of new medical procedures, drugs, devices, and new applications of already existing technologies. If the medical breakthrough passes all the rigorous medical tests and is of benefit to the member, it is considered as a diagnostic or treatment option for the member.

New medical technology is reviewed against specific criteria and clinical research for its effectiveness. Texas Health Choice solicits input from local and national specialties during the review process.

The new technology must:

- be approved by the appropriate government regulatory body (for example, Food and Drug Administration approves new pharmaceutical drugs)
- demonstrate a positive effect and improve health outcomes
- be as beneficial as any established alternatives
- be able to demonstrate improvement outside the investigational setting
- demonstrate cost effectiveness

Requests for review of a NEW medical technology review may be submitted by physicians, health plan members, and other interested parties.

Medical necessity

Medically necessary means a service needed to improve a specific health condition or to preserve your health and which is determined by us to be: Consistent with the diagnosis and treatment of the member's illness or injury; the most appropriate level of service which can be safely provided to you and not soley for your convenience or that of your provider or the hospital.

When applied to inpatient services, Medically necessary" further means that your condition requires treatment in a hospital rather than in any other setting. Services and accommodations will not automatically be considered Medically necessary because they were prescribed by a physician.

Plan allowance

Plan allowance (or Eligible Medical Expense (EME)) is the amount we use to determine our payment and your coinsurance for covered services. Fee for service plans determine their allowance in different ways. We determine our allowance based on Medicare reimbursement. Plan providers have agreed to accept this amount plus any copayment amount as payment in full.

Us/We

Us and we refer to Texas Health Choice, L.C.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you *a Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- 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;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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 (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.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

· **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees, or other information about your coverage choices.

· **TCC**

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

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

Get the RI 79-27, which describes TCC, and the RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees, from your employing or retirement office or from www.opm.gov/insure.

· **Converting to individual coverage**

You may convert to an individual policy if:

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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 1-800-466-8397 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

· **Penalties for Fraud**

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2001. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA

When you can join

You may enroll under the FEHB/ DoD Demonstration Project during the 2000 open season, November 13, 2000, through December 11, 2000. Your coverage will begin January 1, 2001. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 2000 and 2001 open seasons. Your coverage will begin January 1 of the year following the open season during which you enrolled.

If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2001 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

TCC eligibility

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

NOTES

Summary of benefits for the *Texas Health Choice* - 2001

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	13
Services provided by a hospital:		
• Inpatient	Nothing	29
• Outpatient	Nothing	30
Emergency benefits:		
• In-area	$50 per visit	32
• Out-of-area	$50 per visit	33
Mental health and substance abuse treatment	Regular cost sharing	35
Prescription drugs	*$6 for preferred generic drugs* *$12 for preferred brand name drugs* *50% of cost for non-preferred drugs*	36
Dental Care		42
• Dental Services, plus	$10 per office visit, plus	
• Oral examinations	$15 per emergency oral exam	
• Topical application of floride	$10 per cleaning	
• Bitewing x-rays (one set every six months)		
• Full mouth series x-rays as reasonable and necessary for dental diagnosis and treatment	No additional charge	
• Emergency dental services received outside the service area	$25 per emergency visit	
Vision Care • Annual eye refractions	$10 per office visit	20
Special features: Medical Advice Line, Services for Deaf and Hearing Impaired, Polypharmacy Clinic, Centers of Excellence for Transplants, Travel benefit/Services overseas.		41
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $600/Self Only or $1,200/Family enrollment per year Some costs do not count toward this protection	11

2001 Rate Information for Texas Health Choice

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide .

		Non-Postal Premium				**Postal Premium**	
		Biweekly		**Monthly**		**Biweekly**	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Location Information							
High Option Self Only	**UK1**	**$71.18**	**$23.72**	**$154.22**	**$51.40**	**$84.22**	**$10.68**
High Option Self & Family	**UK2**	**$182.19**	**$60.73**	**$394.75**	**$131.58**	**$215.59**	**$27.33**