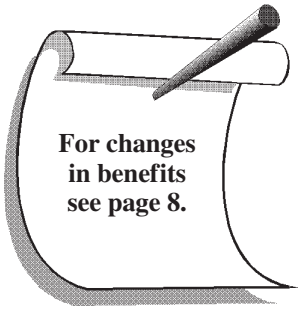
FIRSTCARE 2002

http://www.firstcare.com

A Health Maintenance Organization



Serving: The entire Texas Panhandle and much of West Texas and the Waco area.

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.

West Texas

Enrollment codes for this Plan:

CK1 Self Only
CK2 Self and Family

Waco Area

Enrollment codes for this Plan:

6U1 Self Only
6U2 Self and Family

Authorized for distribution by the:

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Introduction

Southwest Health Alliances (SHA), L.L.C., dba FIRSTCARE
12940 Research Blvd.
Austin, Texas 78750

This brochure describes the benefits of FIRSTCARE under our contract (CS 2321) 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management Office of Insurance Planning and Evaluation Division, 1900 E Street, NW, Washington DC 20415.

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 806/356-5155 or 800/884-4901 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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.

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 and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

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.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. 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.

- We have been operational since June, 1986, and we have been providing quality healthcare to Federal employees since January 1, 1988.
- As a state certified and federally qualified health plan, FIRSTCARE is in compliance with all the rules and regulations of these governing bodies.
- FIRSTCARE is a limited liability company.
- We are an Individual Practice Prepayment (IPP) Plan. We contract with approximately 721 PCPs, 1156 Specialists and 63 hospitals in our Waco and West Texas service areas.

If you want more information about us, call 806/356-5155 or 800/884-4901, or write to 3310 Danvers, Amarillo, TX 79106. You may also contact us by fax at 806/356-5263 or visit our website at www.firstcare.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

In **West Texas**, the counties of Andrews, Armstrong, Bailey, Borden, Brewster, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crane, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Ector, Floyd, Gaines, Garza, Glasscock, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Howard, Hutchinson, King, Lamb, Lipscomb, Loving, Lubbock, Lynn, Martin, Midland, Moore, Motley, Ochiltree, Oldham, Parmer, Pecos, Potter, Randall, Reagan, Reeves, Roberts, Scurry, Sherman, Swisher, Terry, Upton, Ward, Wheeler, Winkler, and Yoakum.

In the **Waco area**, the counties of Bell, Bosque, Brazos, Burleson, Burnet, Coryell, Falls, Freestone, Grimes, Hamilton, Hill, Houston, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Navarro, Robertson, San Saba, Somervell, Walker, and Washington.

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 unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. FIRSTCARE will only provide coverage for emergency care outside our service area. 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 2002

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

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- Your share of the non-Postal premium for Enrollment Code CK will decrease by 20.8% for Self Only or 24.8% for Self and Family. Enrollment Code 6U will increase by 25.1% for Self Only or 16.2% for Self and Family.
- We now cover certain intestinal transplants. (Section 5(b))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- For emergency care received at any doctor's office, outside our Plan's service area, you will be subject to a $15 copay per office visit, plus all amounts over our Plan allowance of Usual, Customary and Reasonable (UCR) charges for the services rendered. (See Section 5(d) and Section 10 for the definition of our Plan allowance of UCR).

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 800/884-4901.

Where you get covered care

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

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

FIRSTCARE services are provided through 721 primary care physicians, 1156 specialists, 63 contracted hospitals and many other health professionals and facilities. FIRSTCARE has been serving FEHB employees and eligible dependents since 1988.

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

- **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 to get covered care

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

Each female member may select an obstetrician-gynecologist (OB/GYN) in addition to her primary care physician. She may go directly to him/her for an annual well-woman examination, care for pregnancy and all gynecological conditions. The OB/GYN may diagnose, treat and refer for any disease or condition within the scope of professional practice of a credentialed obstetrician or gynecologist.

Services of other providers are covered only when your primary care physician has referred you.

- **Primary care**

Your primary care physician can be a family practitioner or an internist and you may select a pediatrician for your children. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see your designated obstetrician/gynecologist (OB/GYN) or seek emergency care without a referral. Your primary care physician will arrange your referral to a specialist. Referral to a participating specialist is given at the primary care physician's discretion, if non-Plan specialists or consultants are required, the primary care physician will arrange appropriate referrals.

When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation unless your doctor authorizes additional visits. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for a return visit unless your primary care physician gives you a referral, and the Plan has issued an authorization for the referral in advance.

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 primary care physician will work with us to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- 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.

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800/884-4901. 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 primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process pre-authorization. Your physician must obtain pre-authorization for certain services, such as outpatient surgery, inpatient hospital admissions, growth hormone therapy (GHT), certain prescription drugs, durable medical equipment (DME) such as oxygen and equipment, etc.

In some cases, charges for medical procedures may not be covered without proper authorization. If you have any questions, call our Customer Services Department at 800/884-4901. Remember, when in doubt, CALL!

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, facility, pharmacy, etc. when you receive services.

  Example: When you see your primary care physician you pay a copayment of $10 per office visit.

- **Deductible**

  We do not have a deductible.

- **Coinsurance**

  Coinsurance is the percentage of our negotiated fee that you must pay for certain services.

  Example: In our Plan, you pay 50% of our allowance for infertility services; and 20% of charges for durable medical equipment.

Your catastrophic protection out-of-pocket maximum for copayments and coinsurance

After your copayments and coinsurance total 200% of annual premium per Self Only enrollment or 200% of annual premium per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurance for prescription drugs, and Durable Medical Equipment (DME) do not count toward your out-of pocket maximum, and you must continue to pay copayments and coinsurance for prescription drug benefits.

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

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 59 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 subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800/884-4901 or at our website www.firstcare.com.

(a) Medical services and supplies provided by physicians and other health care professionals 15-24

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Physical and occupational therapies
- Speech therapy
- Hearing services (testing, treatment, and supplies)
- Vision services (testing, treatment, and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Chiropractic
- Alternative treatments
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals 25-28

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services 29-31

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents 32-34

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits 35

(f) Prescription drug benefits 36-40

(g) Special features 41

- Services for deaf and hearing impaired
- Centers of excellence for transplants/heart surgery/etc.

(h) Dental benfits 42

Summary of benefits 59

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.
- 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 to your primary care physician $15 per office visit to a specialist
Professional services of physicians • In an urgent care center	$25 per visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing
Professional services of physicians • Office medical consultations • Second surgical opinion	$10 per office visit to your primary care physician $15 per office visit to a specialist
Professional services of physicians • At home	$20 per visit

Lab, X-ray and other diagnostic tests	You pay
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: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including: – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older • Routine PAP test Routine mammogram – covered for women age 35 and older, as follows: • From age 35 to 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 • Routine immunizations according to generally accepted medical practice standards and the U.S. Public Health Service for people in the United States, including immunizations for travel outside the United States. • Eye screenings, biennially, for members age 19 and older for the purpose of determining vision loss • Hearing screenings, biennially, for members age 19 and older for the purpose of determining hearing loss • Speech screenings, biennially, for members age 19 and older for the purpose of determining speech impairment	Nothing if you receive these services during your office visit
Not covered: Physical exams, health reports and/or treatments required for employment, insurance, school, camp, travel, fight clearance, sports or legal proceedings	*All charges*

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics or those required by the Texas Department of Health	Nothing
• Well-child care charges for routine examinations, immunizations and care (through age 22).	$10 per office visit to your primary care physician
• Examinations, such as: – Eye screenings, annually, through age 18 to determine vision loss. – Ear screenings, annually, through age 18 to determine hearing loss. – Speech screenings, annually, through age 18 to determine speech impairment	Nothing if you receive these services during your office visit
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • Your physician will pre-authorize your normal delivery; see page 11 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. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • 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: Sonograms to determine sex*	*All charges*

Family planning	You pay
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as, Norplant). • Injectable contraceptive drugs (such as, Depo Provera) • Diaphragms • Intrauterine devices (IUDs) Note: We cover oral contraceptives under the prescription drug benefit. There is no charge when Norplant is implanted during a covered hospitalization. There will be no refund of any portion of the coinsurance if the implanted time-release medication is removed before the end of its expected life.	20% of charges
Not covered: Reversal of voluntary surgical sterilization, genetic counseling and testing, except for medically necessary prenatal genetic testing.	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • Fertility drugs • Lab and x-ray services Note: We cover injectable fertility drugs administered by Plan providers under medical benefits and self-administered injectable and oral fertility drugs under the prescription drug benefit.	50% of charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *In vitro fertilization* – *Embryo transfer, gamete GIFT and zygote GIFT* – *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Surrogate parenting fees* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*

Allergy care	You pay
• Testing and treatment	$15 per office visit to a specialist
• Allergy injection, when administered without an office visit.	50% of charges
• Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 27. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing
• Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: – We will only cover GHT when we authorize the treatment. We will ask your physician to submit information that establishes that the GHT is medically necessary. Your physician needs to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date your physician submits the information. If your physician does not ask or if we determine 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.	See Prescription Drug benefit.
Physical and occupational therapies	
• Physical therapy and occupational therapy services of each of the following: – Qualified physical therapists; and – Occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	$15 per office or outpatient visit; nothing inpatient.

Physical and occupational theraphies continued on the next page

Physical and occupational therapies *(Continued)*	**You pay**
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction must be provided at a Plan facility, and is covered for up to two months per condition, or for up to 60 days per condition per calendar year, whichever is greater, if significant improvement can be expected within that time. Note: Your coverage is limited to services that continue to meet or exceed the treatment goals established for you. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of other deterioration.	$15 per office or outpatient visit; nothing inpatient.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	
• Speech therapy services provided by a speech therapist	$15 per office or outpatient visit; nothing inpatient.
Hearing services (testing, treatment, and supplies)	
• Hearing screenings, annually, for children through age 18 (see *Preventive care, children*) • Hearing screenings, biennially, for members age 19 and older (see *Preventive care, adult*)	$10 per office visit to your primary care physician $15 per office visit to a specialist
• Hearing aids Note: Must be medically necessary as determined by a Plan physician, authorized in advance by the Plan, and obtained from a Plan provider.	Nothing up to Plan maximum of $500 per ear once every 36 months; all charges over $500 per ear.
Not covered: • *Repair or replacement of hearing aids due to normal wear and tear and loss or damage*	*All charges*
Vision services (testing, treatment, and supplies)	
• Eye screenings, annually, for children through age 18 to determine vision loss (see *Preventive care, children*) • Eye screenings, biennially, for members age 19 and older to determine vision loss (see *Preventive care, adult*)	Nothing if you receive these services during your primary care physician office visit
Not covered: • *Eyeglasses, frames, or contact lenses (including the fitting of contact lenses), except as necessary for the first pair of corrective lenses following cataract removal* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Refractions, including lens prescriptions, to determine the need for glasses or contacts.*	*All charges*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per visit to your primary care physician $15 per visit to a specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* • *Treatment of weak, strained or flat feet, spurs, and treatment of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Foot orthotics • Podiatric appliances for the prevention of complications associated with diabetes. • Braces (limb or back only)	20% of charges
• Internal prosthetic devices, such as artificial joints, pacemakers, surgically implanted breast implant following mastectomy, and implanted lenses during cataract surgery. Note: See 5(b) for coverage of the surgery to insert the device.	Nothing
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements, except for breast prostheses and surgical bras, and as necessitated by bodily growth.* • *Cochlear implanted device* • *Wigs or prosthetic hair* • *Implanted neurological stimulators, including but not limited to spinal or dorsal column stimulators for relief of pain, Parkinson's, movement disorders or seizures.*	*All charges*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen (see below) and dialysis equipment. Under this benefit, we also cover: • Manual hospital beds • Manual wheelchairs • Crutches • Canes • Walkers • Braces (limb or back only) • Traction devices • Nebulizers • Indwelling urinary catheters • C-PAP monitoring device (when there is a diagnosis of documented obstructive sleep apnea) • Oxygen, oxygen concentrators, rental of equipment for administration of oxygen, and mechanical equipment necessary for the treatment of chronic or acute respiratory failure Note: Oxygen and equipment must be prescribed and directed by a Plan provider, and approved in advance by the Plan. • Monitoring devices, such as apnea monitors and uterine monitors for use in the home, when prescribed and directed by a Plan provider • Ostomy supplies • Sterile dressing change kits, i.e., tracheostomy suction and dressing kits, and central line dressing kits • Equipment and supplies used for the treatment of diabetes as follows: – Blood glucose monitors, including monitors designed to be used by blind individuals – Insulin pumps and associated appurtenances – Insulin infusion devices – Podiatric appliances for the prevention of complications associated with diabetes – Glucose monitors – Injection aids – Insulin cartridges – Infusion sets Note: DME must be pre-authorized, unless it is provided by your physician's office.	20% of charges

Durable medical equipment (DME) continued on the next page

Durable medical equipment (DME) *(Continued)*	**You pay**
Not covered: • *Motorized, deluxe, and custom wheelchairs and hospital beds; auto tilt chairs.* • *Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, and exercise equipment.* • *Environmental control equipment, such as air conditioners, purifiers, humidifiers, de-humidifiers, electrostatic machines and heat lamps.* • *Institutional equipment, such as fluidized beds and diathermy machines.* • *Consumable medical supplies, such as over-the-counter bandages, dressings and other disposable supplies and skin preparations.* • *Foam cervical collars.* • *Stethoscopes, sphygmomanometers, reading oximeters.* • *Hygienic or self help items or equipment.* • *Sports cords.* • *TENS units.* • *Repair or replacement resulting from misuse or abuse.*	*All charges*
Home health services	
• Home health care visits ordered by a Plan physician and provided by a skilled home health care professional or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	
No benefit.	*All charges*

Alternative treatments	
• Telemedicine to deliver health care, which includes use of interactive audio, video, or other electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education, but excludes services performed using a telephone or facsimile (FAX) machine.	Nothing
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupuncture* • *Equine or Hippo therapy* • *Massage therapy, unless associated with a physical therapy modality provided by a licensed physical therapist*	*All charges*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management training, including counseling and use of diabetic equipment and supplies. • Nutritional counseling for morbid obesity.	$10 per office visit to your primary care physician $15 per office visit to a specialist

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 or arrange your care.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- Assistant surgeon services will be covered for those surgeries which require an assistant surgeon and when we pre-approve them.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Treatment of burns • 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 • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker, and Surgery benefits for insertion of the pacemaker.	Nothing
• Voluntary sterilization	20% of charges

Surgical procedures continued on next page

Surgical procedures *(Continued)*	**You pay**
Not covered: • *Reversal of voluntary sterilization.* • *Any surgical procedures related to snoring and sleep apnea.* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance, and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • 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 the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
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	You pay
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 • Treatment of temporomandibular joint (TMJ) surgery, including surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy and other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures or related dental work that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/Lung • Kidney • Kidney/Pancreas • Liver • Lung: Single–Double • Pancreas • Allogenic (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. • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas.	Nothing

Organ/tissue transplants continued on next page

Organ/tissue transplants *(Continued)*	**You pay**
Note: Immuno-suppressive medications necessary to prevent rejection of any transplanted organ listed above are covered subject to no copay while hospitalized. After discharge, these medications are covered under the Prescription drug benefit and subject to the applicable prescription drug copay per 30-day supply. They are not available through the Mail Order Pharmacy. Note: All covered transplants must be evaluated by a nationally recognized medical facility designated by FIRSTCARE and they must agree that the proposed transplant is appropriate for the treatment of your condition. Also, they must agree to perform the transplant. The FIRSTCARE Medical Director must approve all covered transplants. All related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.	
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • 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 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 Sections 5(a) or (b).
- YOUR PHYSICIAN MUST GET PREAUTHORIZATION OF HOSPITAL STAYS. Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: • Ward, semiprivate room or intensive care accommodations; • Private rooms and/or special duty nursing when medically necessary • 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. 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 • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	Nothing

Inpatient hospital continued on next page

Inpatient hospital *(Continued)*	**You pay**
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Take-home drugs*	*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 • 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
Extended care benefits/skilled nursing care facility benefits	
Extended care benefit: A comprehensive range of benefits to a maximum of 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 a Plan doctor and approved by the Plan. • Bed, board and general nursing care. • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing
Not covered: • *Custodial care* • *Rest cures* • *Domiciliary or convalescent care*	*All charges*

Hospice care	You pay
We cover supportive and palliative care in the home or a hospice facility. Services include: – Inpatient and outpatient care, and – Family counseling. Note: A Plan physician must certify that the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less.	Nothing
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	$75 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.
- 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.
- Our Plan's allowance of Usual, Customary and Reasonable (UCR) charges will apply to emergency care received at any doctor's office outside our Plan's services area for the services rendered. (See next page and Section 10 for the definition of our Plan's allowance of UCR charges).

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:

Emergencies within our service area:

If you are in an emergency situation, please call your primary care physician right away. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (such as, the 911-telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a FIRSTCARE member so they can notify us. You or a family member should notify FIRSTCARE within 24 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that we have been notified in a timely manner.

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.

Emergency care includes the following services:

- An initial medical screening examination by the facility providing the emergency care or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists.
- Services for the treatment and stabilization of an emergency condition.
- Post-stabilization care originating in a hospital emergency room or comparable facility, if approved by us, provided that we must approve or deny coverage within one hour of a request for approval by the treating physician or the hospital emergency room.

Requirements for All Emergency Care. To be covered, emergency care must meet all of these conditions:

- You must obtain the services immediately, or as soon as possible, after the emergency condition occurs.
- As soon as possible after the emergency occurs and you seek treatment, you (or someone acting for you) must contact your primary care physician for advice and instructions. In any event, you must contact the Plan within 24 hours, unless it is impossible to do so.

You must be transferred to the care of Plan providers as soon as this can be done without harming your condition. We do not cover services provided by non-Plan providers after the point at which you can be safely transferred to the care of a Plan provider.

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, FIRSTCARE must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify Us 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 ambulance charges covered in full.

Any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per office visit to your primary care physician $15 per office visit to a specialist
• Emergency care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$75 per visit; if admitted, the copay is waived. However, if admitted for an observation period of less than 24 hours, the copay is not waived.
Not covered: • *Elective care or non-emergency care*	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office	$15 per office visit, plus all amounts over our Plan's allowance of the Usual, Customary and Reasonable (UCR) charges for the services rendered.
• Emergency care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$75 per visit; if admitted, the copay is waived. However, if admitted for an observation period of less than 24 hours, the copay is not waived.

Emergencies outside our service area continued on the next page

Emergency outside our service area *(Continued)*	**You pay**
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* • *Charges for the normal delivery of a baby (vaginal or cesarean section) outside our Plan's Service Area, if the delivery is within 30 days of your due date specified by your participating physician, except in case of emergency; however, complications of pregnancy or premature delivery are covered.*	*All charges*
Ambulance	
• Professional ambulance service, including air ambulance, when medically appropriate. See 5(c) for non-emergency service.	$75 per trip

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

IMPORTANT

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

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	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$15 per office visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, 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 one clinically appropriate treatment plan in favor of another.*	*All charges*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of our network authorization processes.
Mental health and substance abuse services are provided through these behavioral health benefit managers:

- In the Amarillo and Lubbock regions (which includes Midland/Odessa): Comprehensive Behavioral Care – 800/541-3647
- In the Waco region: MHNet, Inc. – 800/336-2030

Your primary care physician may refer you, or you may contact the benefit manager for your region without a referral.

Limitation

If you do not obtain an approved treatment plan, we may limit your benefits.

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.
- 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.**

  A Plan physician or dentist, or an out-of-Plan doctor when you have been referred must write the prescription.

- **Where you can obtain them.**

  – **Retail Pharmacy**

  You may fill your prescriptions at a retail Plan pharmacy, or

  – **Mail Order Pharmacy**

  You may obtain a medication for chronic conditions through the Plan mail order pharmacy. Medications for chronic conditions are defined as those that you have taken for at least six months. Our mail order pharmacy for the Amarillo region is Maxor Pharmacies 800/687-8629 and for the Waco and Lubbock regions is Express Scripts 888/202-4560.

- **We use a formulary.**

  Our drug formulary includes all generic drugs and a comprehensive list of preferred name brand drugs approved by our Pharmacy and Therapeutics (P&T) Committee, and used by Plan physicians to be dispensed through our Plan pharmacies to meet patient needs at a lower cost. You must use drugs included on the formulary to take advantage of the best combination of safety, effectiveness and cost savings. Drugs not included in the formulary are called "non-formulary" drugs and you must pay a higher copayment for these drugs. If you need to order a drug formulary or have any questions, please call our Customer Services Department at 800/884-4901.

- **These are the dispensing limitations.**

  FIRSTCARE requires prior authorization and imposes dispensing limitations on certain drugs, due to specific therapeutic indications or requirements for closer monitoring to help insure appropriate dispensing. The criteria used in administering these programs follow FDA approved dosing guidelines. For specific information about your prescription coverage, please consult a Customer Services Representative at 800/884-4901.

  Prescriptions are limited to a 30-day supply, except medications for chronic conditions that may be filled up to a 90-day supply, but only when filled through a Participating Mail Service Pharmacy.

  All generic equivalent drugs are covered when used to treat a covered medical condition. Name brand drugs are covered when a generic equivalent is available; however, if your physician has not specified Dispense as Written for the name brand drug, you have to pay the generic copay plus the difference in cost between the name brand and the generic drug.

Prescription drug benefits begin on the next page

- **What should I do if I am at the pharmacy and find out that my prescription is not on the FIRSTCARE formulary list?**

  Your pharmacist should contact your physician's office and explain the circumstances. Your physician may change your prescription to a formulary drug, or if you prefer, you may pay a higher copay to obtain the non-formulary drug.

- **Why use generic drugs?**

  Generic drugs are lower-priced drugs that are pharmaceutically and therapeutically equivalent in strength and dosage to the more expensive original name brand product. The U.S. Food and Drug Administration closely regulates both generic and name brand drugs to ensure they meet the same standards for safety, purity, strength and effectiveness. Generic drugs are less expensive for you – and us – and can reduce your out-of-pocket expenses.

- **When you have to file a claim.**

  You may have to file a claim for reimbursement if you are out of the service area and have to pay for an emergency prescription filled at an out-of-network pharmacy. To obtain these forms, call our Customer Services department at 800/884-4901.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician or dentist and obtained from a Plan retail pharmacy or through our mail order program: • Drugs and medicines that by Federal law require a physician's prescription for their purchase, except as *Not Covered.* • Formulas necessary for the treatment of a heritable disease, such as phenylketonuria (PKU). • Drugs for sexual dysfunction are subject to dosage limits set by the Plan. Contact the Plan for details. • Oral contraceptive drugs. • Prescription and non-prescription oral agents for controlling blood sugar levels. • Growth hormone therapy (GHT) drugs	*Retail Pharmacy,* for up to a 30-day supply per prescription unit or refill: A $10 copay for generic drugs; A $20 copay for name brand drugs when a generic equivalent is not available; A $30 copay for non-formulary drugs; and A $10 copay for name brand drugs when a generic equivalent is available, plus the difference between the cost of the generic drug and the cost of the name brand drug. *Mail Order Pharmacy,* for up to a 90-day supply per prescription unit or refill: A $20 copay for generic drugs; A $40 copay for name brand drugs when a generic equivalent is not available; A $60 copay for non-formulary drugs; and A $20 copay for name brand drugs when a generic equivalent is available, plus the difference between the cost of the generic drug and the cost of the name brand drug.
• Insulin, insulin analogs, and glucagon emergency kits.	Retail Pharmacy: A $20 copay per prescription unit or refill for name brand drugs. Mail Order Pharmacy: A $40 copay per prescription unit or refill for name brand drugs.
• Oral and injectable fertility drugs	50% of charges

Covered medications and supplies continued on the next page

Covered medications and supplies *(Continued)*	**You pay**
• Contraceptive drugs and devices, such as: – Diaphragms – Intrauterine devices (IUDs) – Implantable drugs, such as Norplant – Injectable drugs, such as Depo Provera • Disposable needles and syringes for the administration of covered medications • Allergy syringes • Diabetic supplies, including: – Test strips for blood glucose monitors – Visual reading and urine test strips – Lancets and lancet devices – Injection aids – Syringes – Needles – Glucose test tablets and test tape – Benedict's solution or equivalent – Acetone test tablets	20% of all charges
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 name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the generic copay plus the difference in cost between the name brand and the generic drug. • We administer a 3-tier formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we have selected to meet patient needs at a lower cost. • A non-formulary drug is a prescription medication that is not on the FIRSTCARE approved formulary list. Non-formulary drugs require a higher copayment. • Prescriptions will not be refilled until 70% of the prescription has been used.	

Covered medications and supplies continued on the next page

Covered medications and supplies *(Continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes.* • *Vitamins, and nutritional substances that can be purchased without a prescription, except for pre-natal vitamins.* • *Non-prescription medicines, except for the treatment of diabetes.* • *Drugs available without a prescription or for which there is a non-prescription equivalent available.* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies.* • *Medical supplies such as dressings and antiseptics.* • *Drugs to enhance athletic performance.* • *Smoking cessation drugs and medication, including nicotine patches.* • *Drugs prescribed for weight loss and appetite suppressants, except for medications prescribed for morbid obesity.* • *Prescription refills in excess of the number specified by the Physician and any refill dispensed more than one year after the Physician's order.* • *Any prescription drug for which the actual cost is less than the required copayment is not covered and you will be responsible for the cost of the drug.* • *Prescriptions or refills that replace lost, stolen, spoiled, expired, spilled or are otherwise misplaced or mishandled by the Member.*	*All charges*

Section 5 (g). Special Features

Feature	Description
Services for deaf and hearing impaired	**TDD LINE 1-800/562-5259**
Centers of excellence for transplants/heart surgery/etc.	FIRSTCARE coordinates with nationally recognized medical facilities to evaluate the Member's case; to determine that the proposed transplant or treatment is appropriate for the Member's condition; and to perform the transplant or treatment.

Section 5 (h). Dental benefits

Accidental injury benefit	You pay
No benefit	*All charges*
Dental benefits	
No benefit	*All charges*

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 *Services requiring our prior approval* on page 12.

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;
- 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 fill your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

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, hospital and drug 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 800/884-4901.

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

Submit your claims to: **FIRSTCARE**
12940 Research Blvd.
Austin, Texas 78750

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 pre-authorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within six months from the date of our decision; and (b) Send your request to our Customer Services Department at 3310 Danvers, Amarillo, Texas 79106; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
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 provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.

The Disputed Claims process *(Continued)*

Send OPM the following information:

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

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

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

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

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

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 or from the year in which you were denied preauthorization. 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 our Customer Services Department at 800/884-4901 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you 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-Stage 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice 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 (Part A or Part B)**

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover you. Your care must continue to be authorized by your Plan PCP, or pre-certified as required. We will not waive any of our copayments or coinsurance.

(Primary payer chart begins on next page.)

The following chart illustrates whether the Original Medicare Plan 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, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

Please note, if Medicare is primary and your Plan physician does not participate in Medicare, you will have to file a claim with Medicare. When you receive your Medicare Explanation of Benefits, you must send a copy to us at 3310 Danvers, Amarillo, Texas 79106, so we can determine the secondary coverage.

Claims process when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your 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 800/884-4901.

We do not waive any 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 another type of Medicare+Choice plan - 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 provide all the benefits that Original Medicare covers. 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 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. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed 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's service area.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

Covered services

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

Custodial care

Custodial care is care that:

- Primarily helps with or supports daily living activities (such as, eating, dressing, and eliminating body wastes); or
- Can be given by people other than trained medical personnel.

Care can be custodial even if it is prescribed by a physician or given by trained medical personnel, and even if it involves artificial methods such as feeding tubes or catheters.

Experimental or investigational services

Determining eligibility of coverage for a new technology requires evaluation of its health effects by the Plan's Medical Advisory Committee, which consists of Medical Directors from all of the Plan's regions and appropriate Ad Hoc Specialists. A service or supply shall be considered to be experimental or investigational as follows:

- If the protocols or consent document of the entity prescribing or rendering the service or supply describes it as an alternative to more conventional therapies;
- Authoritative medical or scientific literature published in the United States and written by experts in the field indicates that additional research is necessary before the service or supply could be classified as equally or more effective than conventional therapies;
- Food and Drug Administration (FDA) approval is required in order for the service or supply to be lawfully marketed, and such approval has not been granted at the time the service or supply is prescribed or rendered; and
- The prescribed service or supply is available to the member only through participation in FDA Phase I or Phase II clinical trials, or through FDA Phase III experimental or research clinical trials or corresponding trials sponsored by the National Cancer Institute.

Group health coverage

Health coverage, such as FEHB, that is provided through an employer group.

Medical necessity

Medical necessity and/or medically necessary means that the service must meet *all* of the following conditions:

- The service is required for diagnosing, treating or preventing an illness or injury, or a medical condition such as pregnancy;
- If you are ill or injured, it is a service you need in order to improve your condition or to keep your condition from getting worse;
- It is generally accepted as safe and effective under standard medical practice in your community; and
- The service is provided in the most cost-efficient way, while still giving you an appropriate level of care.

Not every service that fits this definition is covered under your Plan. Just because a physician or other health care provider has performed, prescribed or recommended a service does not mean it is a medical necessity and/or medically necessary or that it is covered under your Plan.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. Our Plan allowance is the amount our contracted providers have agreed to accept as payment in full.

For emergency care received at any doctor's office, outside our Plan's service area, our Plan's allowance is the amount FIRSTCARE has determined to be the allowable prevailing charge for a particular professional service in the geographical area in which the service is performed.

Usual, Reasonable and Customary (UCR) charge

The UCR charge is the amount we have determined to be the allowable prevailing charge for a particular professional service in the geographical area in which the service is provided.

Us/We

Us and we refer to FIRSTCARE.

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

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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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 of coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

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

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

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.

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal 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. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

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

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

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB website (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long-term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) inurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many people now consider long-term care insurance to be vital to their financial and retirement planning.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8-hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for FIRSTCARE – 2002

- **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; $15 specialist	15
Services provided by a hospital:		
• Inpatient	Nothing	29
• Outpatient	Nothing	30
Emergency benefits:		
• In-area	$75 per emergency room visit; waived if admitted	32
• Out-of-area	$75 per emergency room visit; waived if admitted	33
Mental health and substance abuse treatment	Regular cost sharing	35
Prescription drugs ..... Retail Pharmacy: For up to a 30-day supply per prescription unit or refill Mail Order Pharmacy: For up to a 90-day supply per prescription unit or refill Note: For additional details about your prescription benefit, please read Section 5 (f).	**Retail Pharmacy:** $10 copay for generic drugs; $20 copay for name brand drugs when a generic is not available; $30 copay for non-formulary drugs; and $10 copay for name brand drugs when a generic drug is available, plus difference in cost between the generic and name brand drugs. **Mail Order Pharmacy:** $20 copay for generic drugs; $40 copay for name brand drugs when a generic is not available; $60 copay for non-formulary drugs; and $20 copay for name brand drugs when a generic drug is available, plus difference in cost between the generic and name brand drugs.	36
Dental Care	No benefit	
Vision Care	No benefit	
Special features: Services for deaf and hearing impaired; Centers of excellence for transplants/heart surgery/etc.		41
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after 200% of annual premium/Self Only or 200% of annual premium/Family enrollment. Some costs do not count toward this protection.	13

2002 Rate Information for FIRSTCARE

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, 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 who are not career postal employees. 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
Waco Area							
Self Only	6U1	$97.86	$38.15	$212.03	$82.66	$115.52	$20.49
Self and Family	6U2	$219.14	$73.04	$474.80	$158.26	$259.31	$32.87
West Texas							
Self Only	CK1	$97.86	$53.31	$212.03	$115.51	$115.52	$35.65
Self and Family	CK2	$223.41	$101.31	$484.06	$219.50	$263.75	$60.97