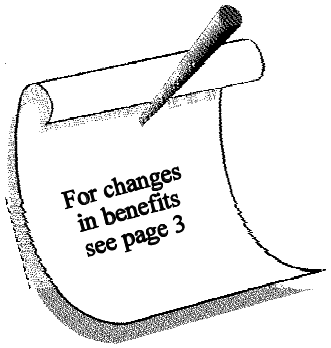
Texas Health Choice, L.C. 2000

Formerly HMO Texas, L.C.

A Health Maintenance Organization



Serving: Dallas and Fort Worth Areas;
Houston and Golden Triangle Areas

Enrollment in this Plan is limited; see pages 5-8 for requirements.
For changes in benefits see pages 3-5.

Enrollment code:

UK1 Self only
UK2 Self and family

Region includes the Dallas/Fort Worth areas

Enrollment code:

2T1 Self only
2T2 Self and family

Region includes the Greater Houston/Golden Triangle areas

Visit the OPM website at http://www.opm.gov/insure
and
This Plan's website at http://www.sierrahealth.com

Authorized for distribution by the:

United State Office of Personal Management Retirement and Insurance Service

Federal Employees Health Benefits Program

RI 73-658

Table of Contents

Introduction

Texas Health Choice, L.C.
9330 Amberton Parkway
Dallas, Tx 75243

Texas Health Choice, L.C.
11011 Richmond, Suite 900
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This brochure describes the benefits you can receive from Texas Health Choice under its contract with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on pages 3-5. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health Plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Texas Health Choice as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the benefits section of this brochure, but some of your benefits have changed in the year 2000. You will find new benefit description language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.

3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.

4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.

7. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.

8. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and shots, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, when you receive services you must pay copayments and coinsurance listed in this brochure. When you receive emergency services 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

To keep your premium as low as possible, OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program.

You may review and obtain copies of your medical records on request. You may ask that a physician amend a record that is not accurate, relevant, or complete. If the physician does not amend your record, you may add a brief statement to the record.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to the Dallas Plan

- Your share of the non-postal premium will increase by 0.2 percent for Self Only or 3.9 percent for Self and Family.
- The out-of-pocket maximum was $1,500 per individual and $3,900 per family, but it has decreased to $600 per individual and $1,200 per family.
- The oral surgical services benefit has been improved and now includes coverage for treatment required to stabilize sound natural teeth, the jawbones, or surrounding tissues after an Accidental Injury when the treatment is initiated within the first ten (10) days. This includes, but is not limited to, coverage for the following: incision and drainage, excision of broken sound and natural teeth, or tooth stabilization through splinting.
- Short-term *inpatient* rehabilitation services were covered at no charge for physical therapy and 20% of charges for chronic pain management, speech therapy and occupational therapy, but now each therapy will be covered at no charge, limited to two months or 30 visits, whichever is greater, per medical episode.
- Short-term *outpatient* rehabilitation services were covered at $5 a visit for physical therapy and 20% of charges for chronic pain management, speech therapy, and occupational therapy, but now each therapy will be covered at $10 a visit, limited to two months or 30 visits, whichever is greater, per medical episode.

Section 2. How we change for 2000 *continued*

Changes to the Dallas Plan
continued

- The benefits for hospice services have been clarified and now include the following: no charge for inpatient hospice care, $10 for bereavement counseling up to 5 visits or $500, whichever is less, and no charge for inpatient and outpatient respite care. The limitation on bereavement services is a year 2000 addition.
- The urgent care facility copay has increased from $5 a visit to $25 a visit.
- The *outpatient* mental health benefit was $20 a visit up to 30 visits per year, but the coverage has improved to $20 a visit for individual therapy and $10 a visit for group therapy with a combined calendar year maximum of 40 visits.
- The *inpatient* calendar year benefit maximum for treatment of substance abuse has decreased from 45 days to 30 days.
- The *outpatient* calendar year benefit maximum for treatment of substance abuse has decreased from unlimited visits to 40 visits.
- The copay for generic prescription drugs has decreased from $10 to $6.
- The copay for brand-name prescription drugs has increased from $10 to $12.
- The mail-order drug copay will remain at two times the generic or brand-name copay. However, the supply will be increased from a 60 day supply to a 90 day supply.
- Non-formulary drugs were covered at the appropriate generic or brand-name copay if the member's provider specified that no substitutions were permitted for the written prescriptions. Now, the non-formulary drug copay has changed to 50% of charges for any non-formulary drug regardless of whether substitutions are permitted.
- Injectable and internally-implanted time-release medications, except Norplant, were covered at $5, times the number of months the medication was to be effective, not to exceed $200. This benefit has changed so that you will now simply pay the appropriate generic or brand-name copay depending on the medication prescribed.

Changes to the Houston Plan

- Your share of the non-postal premium has decreased by 7.1 percent for Self Only or 4.7 percent for Self and Family.
- The point-of-service benefit is no longer available.
- The sterilization benefit was no charge. Now there is a charge of $75 for a vasectomy and $200 for a tubal ligation.
- Diagnosis and treatment of infertility was covered at $10 a visit. Now copays have increased to 50% of charges per visit.
- Previously, we did not provide coverage for infertility drugs. Now we will provide coverage with a copay of 50% of charges.
- The Skilled Nursing Facility benefit was unlimited. Now it will have a 100 days per calendar year limit.
- The substance abuse outpatient lifetime maximum has been eliminated.
- Durable medical equipment was covered with a 30% copay. Now the copay has been lowered to 20% of charges.
- Orthotic and prosthetic devices were covered at no charge. Now the copay has increased to 20% of charges.
- The copay for self-management education and training of diabetics has increased from no charge to $10 a visit.
- The copay for brand-name drugs has decreased from $15 to $12.
- Injectable and time-released medications, except Norplant, were covered same as any other drug without a benefit limit. Now they are covered at the appropriate generic or brand-name copay times the number of months the medication will be effective, not to exceed $200.
- The copay for erectile dysfunction drugs has increased from the appropriate generic or brand-name copay to 50% of charges.
- The dental prophylaxis (cleaning) benefit copay has decreased from $20 a visit to $10 a visit.
- The dental bitewing X-ray benefit copay has decreased from $10 a visit to no charge.

Section 2. How we change for 2000 *continued*

Changes to the Houston Plan
continued

- The dental complete series X-ray benefit copay has decreased from $25 a visit to no charge when reasonable and necessary for dental diagnosis and treatment.
- A dental emergency oral exam benefit has been added with a $15 copay per visit inside the service area and $25 copay per visit outside the service area.
- A discount of 15% has been added for additional dental services not covered.
- A vision benefit has been added to the core medical plan and taken out of the non-FEHBP benefit. The old plan offered discounts only. Now, the core vision plan exam is $10 a visit and the glasses, frames and contact lenses are 20% of charges.

Section 3. How to get benefits

What is this Plan's service area?

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

Our service area is comprised of the following full counties in North Central Texas:

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

Our service area is comprised of the following full counties in the Houston and Golden Triangle Areas:

Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Grimes, Harding, Harris, Jefferson, Liberty, Matagorda, Montgomery, Orange, San Jacinto, Waller and Wharton

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services.

If you or a covered family member travels frequently or lives away from home part of the year, you should be aware that benefits for care outside the service area are restricted to emergency care and care received at contracting providers in other areas of the continental United States. Contact the Plan for further details on services available from providers that have a contractual arrangement with Texas Health Choice, L.C., or an affiliate organization.

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

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percent of charges). Please remember you must pay this amount when you receive services, except for the following services: prenatal care, routine immunizations and boosters from birth to 6 years of age, laboratory and X-ray services, complex diagnostic services, physician house calls, home health care, inpatient hospital services, inpatient surgical services, anesthesia, outpatient surgical services, short-term inpatient rehabilitation services, skilled nursing facility care, inpatient hospice care, respite care, inpatient mental health services, inpatient substance abuse services, transplant services, and diabetic supplies.

After **you pay** $600 in copayments or coinsurance for one family member, or $1,200 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs and dental services do not count toward these limits and you must continue to make these payments.

Section 3. How to get benefits *continued*

Do I have to submit claims?

Be sure to keep accurate records of your copayments and coinsurance, since you are responsible for informing us when you reach the limits.
You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care in Dallas?

Texas Health Choice, L.C., offers comprehensive health care coverage on a pre-paid basis at Plan facilities conveniently located throughout the Dallas/Ft. Worth metropolitan area and through referral specialists, hospitals, and other providers in the community. All care should be received at these facilities and from these providers except in medical emergencies.

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

You must choose a primary care doctor when you choose this Plan. The Texas Health Choice provider directory lists primary care providers with their locations, and phone numbers. (Primary care doctors generally include family practitioners, pediatricians, and internists.) With one exception for OB-GYN doctors, the primary care doctor you select will determine which set of specialty physicians you may access. For example, if you select a primary care doctor affiliated with our contracted IPA, you will only be able to access specialists affiliated with the IPA and not The Medical Group of Texas.

In addition to selecting a primary care doctor, we also request that female members over the age of 14 select an OB-GYN at the same time they select a primary care doctor. OB-GYN doctors may be accessed directly without referral from a primary care provider. Also, members may select an OB-GYN from any of Texas Health Choice's network of providers regardless of whether the OB-GYN is part of their primary care provider's network.

Who Provides My Health Care in Houston?

This plan has been approved as an Individual Practice Association (IPA) model plan. Texas Health Choice's Physician network is comprised of sixteen (16) contracted IPAs. The contracted IPAs consist of over 375 Primary Care Physicians (PCPs) and 1,000 specialist physicians. The Plan also contracts with 34 area hospitals.

You must choose a primary care doctor when you choose this Plan. The Texas Health Choice provider directory lists primary care providers with their locations and phone numbers. Primary care doctors generally include family practitioners, pediatricians, and internists. You may select one of the Plan's PCPs from any one of the IPAs. The primary care doctor you select will determine which set of specialty physicians you may access.

In addition to selecting a primary care doctor, we also request that female members over the age of 14 select an OB-GYN at the same time they select a primary care doctor. OB-GYN doctors may be accessed directly without referral from a primary care provider.

Texas Health Choice, L.C., offers comprehensive health care coverage on a pre-paid basis at Plan contracted specialists, hospitals, and other providers conveniently located throughout the Houston and Golden Triangle area. All care should be received at contracted facilities and from contracted providers except in medical emergencies.

Section 3. How to get benefits *continued*

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan doctor. If you need to be hospitalized, your primary care provider or specialist will make the necessary hospital arrangements and supervise your care.

If you are in an emergency situation and need to be hospitalized, please contact us at the number listed on the back of your membership card.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or as soon as possible following your admission. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

What do I do if I'm in the hospital when I join this Plan?

First, call our Member Service department at 1-800-466-8397. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Talk to your doctor. Your primary care provider will arrange for your referral to a specialist. It is the responsibility of your primary care provider to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other Plan providers and non-Plan providers are covered only when there has been a referral by your primary care provider.

If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan and must request approval from a Texas Health Choice Medical Director.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide 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.

What do I do if my 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.

Section 3. How to get benefits *continued*

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

How do you decide if a service is experimental or investigational?

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

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

The new technology must:

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

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

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording in explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information.

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

What if you have denied my request for care and my condition is serious or life threatening?

If your condition is serious or life threatening, call us. We will work with you to expedite the review of your claim. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

What if you have a serious or life threatening condition and you haven't responded to my request for service?

Call us at (202) 606-0755 and we will expedite our review.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.

2. You provided us with additional information we asked for, and we do not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

Section 4. What to do if we deny your claim or request for service *continued*

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

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

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2 The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where Should I mail my disputed claim to OPM?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division 3, P.O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. BENEFITS

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $10 office visit copay, but no additional copay for laboratory tests and X-rays. Within the service area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate; **you pay** nothing for a doctor's house call and home visits by nurses and health aides.

Copayments for surgery are as shown under Limited benefits.

The following services are included and are subject to the office visit copay unless stated otherwise:

- Preventive care, including well-baby care and periodic check-ups.
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through age 49, one mammogram every one or two years; for women age 50 through age 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. **You pay** nothing. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Fecal occult blood test for members age 40 and over. Sigmoidoscopy screening every 5 years starting at age 50.
- Routine immunizations and boosters, including inactivated poliovirus vaccine (IPV) at 2 and 4 months of age. **You pay** nothing.
- Consultations by specialists.
- Diabetic education and training. **You pay** nothing.
- Diagnostic procedures, such as laboratory tests and x-rays. **You pay** nothing.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. **You pay** nothing for office visits to Plan doctors for prenatal and postnatal care. Complete obstetrical (maternity) care for covered females, including all prenatal delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services. **You pay** $75 for a vasectomy and $200 for a tubal ligation.
- Diagnosis and treatment of diseases of the eye.
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum).
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, kidney and liver transplants, lung (single or double), heart/lung, kidney/pancrease; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) and autologous bone marrow transplants 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. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis. **You pay** nothing.

Section 5. BENEFITS *continued*

What is covered
continued

- Chemotherapy, radiation therapy, and inhalation therapy. **You pay** nothing.
- Surgical treatment of morbid obesity
- Prosthetic devices, such as artificial limbs and lenses following cataract removal (initial device covered only). Covered prostheses also includes breast prostheses (including the surgical bra for an external prosthesis) following a mastectomy. We will also cover necessary replacement prostheses and bras as well. **You pay** 20% of charges.
- Durable medical equipment and diabetic equipment. **You pay** 20% of charges.
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need. **You pay** nothing.
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you.
- Blood and blood derivatives
- Surgical procedures are no charge for all procedures, except those performed in the doctor's office which alone are subject to a $10 copayment per procedure in addition to the office visit copayment; however, sterilizations performed in a doctor's office are $75 for a vasectomy and $200 for a tubal ligation. Inpatient surgical procedures are no charge.

Limited benefits

- Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.
- Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and their attending physician will decide whether or not to have breast reconstruction surgery following a medically necessary mastectomy, including whether or not to have surgery on the other breast in order to produce a symmetrical appearance.
- Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition or 30 visits, whichever is greater per medical episode. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living; **you pay** nothing for inpatient sessions and a $10 copay per outpatient session.
  Subject to the benefit maximums outlined above, medically necessary physical therapy, occupational therapy and speech therapy will not be denied, limited or terminated and will continue to be covered provided your condition improves and you continue to meet or exceed treatment goals. If at any point in treatment, a Texas Health Choice Medical Director determines that treatment goals will not be met, the rehabilitative services will no longer be covered. Treatment goals include recovery, restoration in function or improvement in the medical condition. Treatment goals for a physically disabled person as determined by a Texas Health Choice Medical Director may include maintenance of functioning or prevention of or slowing of further deterioration.
- Diagnosis and treatment of infertility is covered; **you pay** $10 per office visit. The following types of artificial insemination are covered: intracervical insemination (ICI), intravaginal insemination (IVI) and intrauterine insemination (IUI). **You pay** 50% of charges. The cost of donor sperm and eggs are not covered. Other assisted reproductive technology (ART) procedures, such as in-vitro fertilization and gamete/ zygote intrafallopian transfers, are not covered.

Section 5. BENEFITS *continued*

Limited benefits *continued*

Drugs related to non-covered infertility services are not covered. Drugs used for covered infertility treatments are provided under the Prescription Drug Benefit at 50% of the charge to members who do not have a prescription drug benefit.

- Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided "at a Plan facility" for up to 36 sessions; **you pay** $10 per visit.

What is not covered

- Chiropractic services
- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- External and internally implanted hearing aids
- Homemaker services
- Long-term rehabilitative therapy
- Transplants not listed as covered
- Orthopedic devices, such as braces and foot orthotics
- Devices, equipment, supplies and prosthetics related to the treatment of sexual dysfunction
- Any eye surgery solely for the purpose of correcting refractive defects in the eye, such as near-sightedness (myopia), foresightedness (hyperopia) and stigmatism

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** nothing. All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care.
- Specialized care units, such as intensive care or cardiac care units.

Extended care

The Plan provides a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay** nothing. All necessary services are covered, including:

- Bed, board and general nursing care.
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

Hospice Care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. **You pay** nothing. Outpatient bereavement counseling for each family member upon the death of a terminally ill member is covered for 5 group therapy visits or a maximum of $500 per calendar year, whichever is less. **You pay** $10 per visit. Respite care for each family member of terminally ill members is covered up to $1,000 per calendar year for outpatient services and $1,500 per calendar year for inpatient services. **You pay** nothing for outpatient and inpatient services.

Section 5. BENEFITS *continued*

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. **You pay** a $50 copay per trip.

Limited benefits

Inpatient Dental Procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines in conjunction with a Texas Health Choice Medical Director that there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for non-medical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Dental hospitalization
- Custodial care, rest cures, domiciliary or convalescent care

Emergency Benefits

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 the Plan may determine are medical emergencies---what they all have in common is the need for quick action.

Emergencies within the service area

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

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

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

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

Plan pays...

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

Section 5. BENEFITS *continued*

Emergency within a service area *continued*

You pay...

$50 per hospital emergency room visit (waived if admitted as an inpatient) or $25 per urgent care center visit for emergency services that are covered benefits of this Plan. $50 per ambulance trip, copayments as shown on page 18 for outpatient/inpatient surgical procedures and outpatient surgical facility visits and inpatient admissions, $25 per non-Plan doctor's office visit, and all charges for services which are not a covered benefit of this Plan.

Emergencies outside the service area

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

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

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

Plan pays...

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

You pay...

$50 per hospital emergency room visit (waived if admitted as an inpatient) or $25 per urgent care center visit for emergency services that are covered benefits of this Plan. $50 per ambulance trip, copayments as shown on page 18 for outpatient/inpatient surgical procedures and outpatient surgical facility visits and inpatient admissions, $25 per non-Plan doctor's office visit, and all charges for services which are not a covered benefit of this Plan.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan; **You pay** $50 per ambulance trip

What is not covered

- Elective care or non-emergency care
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area

Filing claims for non-plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 14.

Section 5. BENEFITS *continued*

Mental Conditions/ Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychiatric treatment (including individual and group therapy)
- Medical management visits, including drug evaluation and maintenance. **You pay** $10 per visit. (These visits are not charged as mental health outpatient visits.)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 40 outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year. **You pay** $10 per visit for group therapy and $20 for individual therapy for covered visits — all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year. **You pay** nothing per covered day of hospitalization— all charges thereafter.

What is not covered

- Care for psychiatric conditions which in the professional judgment of Plan doctors are not subject to significant improvement through relatively short- term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing, except when needed as part of a medical evaluation

Serious Mental Illness

What is covered

Serious mental Coverage is provided for the medically necessary care, diagnosis, and treatment of serious mental illnesses. “Serious mental illness” means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- schizophrenia;
- paranoid and other psychotic disorders;
- bipolar disorders (hypomanic, manic, depressive, and mixed);
- major depressive disorders (single episode or recurrent);
- schizo- affective disorders (bipolar or depressive);
- pervasive developmental disorders; and
- obsessive- compulsive disorders; and
- depression in childhood and adolescence.

Outpatient care

Up to 60 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year. **You pay** $10 for each covered visit - all charges thereafter. An outpatient visit for the purpose of medication management does not count toward this 60 visit limit. **You pay** $10 for each covered visit for medication management.

Section 5. BENEFITS *continued*

Inpatient care

Up to 45 days of inpatient treatment each calendar year. **You pay** nothing.

Substance Abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non- psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

Up to 40 outpatient visits to Plan providers for treatment each calendar year; treatment for individual group and family counseling is covered to a maximum of 4 separate series of treatment per member; **you pay** a $10 copay for each covered visit — all charges thereafter.

Inpatient care

Up to 30 days per calendar year in a substance abuse rehabilitation (intermediate care) program in an alcohol detoxification or rehabilitation center approved by the Plan; **you pay** nothing during the benefit period — all charges thereafter.

What is not covered

- Treatment that is not authorized by a Plan doctor.
- All charges if the member does not complete the substance abuse treatment program.
- Substance abuse treatment on court ordered or as a condition of parole or probation, unless determined by a Texas Health Choice Medical Director to be to be necessary and appropriate.

Prescription Drug Benefits

What is covered

- Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. **You pay** a $6 copay per prescription unit or refill for generic drugs and a $12 copay for brand-name drugs when no generic equivalent is available.
- If you select a brand name drug when a generic equivalent is available and your doctor has not specified that only a brand name is sufficient, **you pay** the amount by which the cost of the brand name drug exceeds the cost of the generic equivalent, in addition to the $6 copayment.
- Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Non-formulary drugs will be covered when prescribed by a Plan doctor. **You pay** a 50% of charges per prescription or refill.

Mail Order Pharmacy Option

A mail order program is available for up to a 90-day supply of covered maintenance medications for the treatment of long-term conditions such as, diabetes, arthritis, heart disease and high blood pressure if authorized by a Plan provider. **You pay** two prescription copayments for up to a 90-day supply.

Covered medications and accessories include:

- Infertility drugs. **You pay** 50% of charges.
- Drugs for which a prescription is required by law
- Insulin, with a copay charge applied to each whole vial up to 40 ml
- Diabetic supplies, including insulin syringes, needles, blood glucose measuring strips, and urine checking reagents. **You pay** nothing.
- Nitroglycerin, phenobarbital or Thyroid U.S.P. When prescribed in quantities of 100, a single copay charge will apply.
- Vitamins which require a prescription
- Disposable needles and syringes needed to inject covered prescribed medication
- Oral contraceptives

Section 5. BENEFITS *continued*

Covered medications and accessories include: *continued*

- Contraceptive devices, injectable and internally implanted time-release medications, except Norplant. **You pay** the generic or brand-name copay times the number of months the medication will be effective, not to exceed $200.
- Implanted contraceptive drugs such as Norplant are covered when other contraceptives are medically inappropriate or are contraindicated. **You pay** 50% coinsurance for charges related to the device, implantation, and removal. There will be no refund of any portion of these copays if the implanted time-release medication is removed before the end of its expected life.
- Erectile dysfunction drugs. **You pay** 50% of charges. Dispensing limitations apply.

Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits.

What is not covered

- Smoking cessation drugs and medications
- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance

Other Benefits

Dental Care

What is covered

The following dental services are covered when provided by participating Plan dentists. You are limited to two visits per calendar year for any combination of the five preventive and diagnostic services listed below. **You pay** $10 per visit, except where noted:

- Oral examinations; **you pay** an additional $15 per emergency oral examination
- Dental prophylaxis (cleaning). **You pay** and additional $10 per visit
- Topical application of fluoride
- Bitewing x-rays (no more than one set every six months)
- Full mouth series x-rays as reasonable and necessary for dental diagnosis and treatment
- Emergency dental services received outside the service area. **You pay** an additional $25 per emergency visit

What is not covered

- Cosmetic dental services
- Replacement of lost or stolen dentures; appliances or bridgework
- Non-emergency care received from non-Plan dentist or non-emergency care received outside of the service area

Vision Care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (which include the written lens prescriptions for eyeglasses) may be obtained from Plan providers. **You pay** a $10 per visit.

What is not covered

- Examinations for fitting of or prescriptions for contact lenses
- Corrective eyeglasses and frames or contact lenses, except as provided on page 18 under Benefits.
- Eye exercises, except for patients for whom amblyopia or strabismus is a concurrent diagnosis.

NON-FEHBP BENEFITS AVAILABLE TO PLAN MEMBERS

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Medicare Prepaid Plan Enrollment

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

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

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

Following your enrollment in Golden Choice, you will be entitled to receive an enhanced benefits package that combines your FEHBP coverage with your Golden Choice benefits.

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

Health Education and Wellness Programs

Our professional health educators, dietitians, exercise physiologists and registered nurses are committed to providing members with the tools necessary for lifelong wellness. In addition to preventive services, such as pediatric immunizations, flu shots and cholesterol screenings, we provide a variety of health education programs. Call (972) 479-5155 or (972) 263-2167 for class schedules and additional information.

Vision Care Services

Optical Fee Schedule

- Contact Lenses (materials only) . . . . . 20% Discount
  (excludes disposable/ programmed replacement lenses, fit and follow- up, professional services and prepaid service agreements)

- Real Value (featuring everyday low package prices) . . . . . 10% Discount
  - Complete pair of glasses (frames and lenses)
  - Choose from selection of over 350 frames

  Single vision . . . . . starting at $109.00
  Bifocal (FT 28) . . . . . starting at $89.00
  Trifocal (7 x 28) . . . . . starting at $119.00

Frames, Lenses and Lens Options * . . . . . 33% Discount

- Choose from over 2,000 frames, including the latest in designer brands.
- Choose from the latest technology in lenses including thinner and lighter Hi- index lenses and anti- reflective coatings.

* Excludes package priced collection.

NON-FEHBP BENEFITS AVAILABLE TO PLAN MEMBERS *continued*

Optical Fee Schedule
continued

Knockabouts & No Rules Collection . . . . . 15% Discount

- Eye Care Centers of America policy is to provide eyewear for all school age children and young adults that only include impact- resistant polycarbonate lenses for maximum eye protection. Therefore, all Knockabout frames are priced to include vision polycarbonate lenses.
- All Knockabout glasses have built- in ultra violet protection, scratch resistant coating and are guaranteed for one year against scratches and breakage.
- Choose from a selection of over 175 frames. Featuring everyday low package prices starting at $87.00

Non- Rx Sunglasses & Accessories . . . . . 20% Discount

Additional Items Not Listed Above . . . . . 20% Discount

You must receive services from participating EyeMasters optical facilities listed in your provider directory. There is no premium charge for this benefit.

Benefits on this page are not part of the FEHB contract.

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 or condition.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 19.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

Section 7. Limitations – Rules that affect your benefits *continued*

Other group insurance coverage *continued*

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

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

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 1-800-466-8397 or write to Texas Health Choice, L.C., P.O. Box 15645, Las Vegas, Nevada 89114-5645. You may also contact us by fax at (702) 242-9350, or visit our website at www.sierrahealth.com.

Section 8. FEHB FACTS *continued*

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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

When are my benefits and premiums effective?

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

What happens when I 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, which is described later in this section.

What types of coverage are available for me and my 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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Are my medical and claims records 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,
- 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your 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 more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- **You pay** the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

When you lose benefits *continued*

How do I enroll in TCC?

If you are leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an individual policy if:

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

If you leave Federal service, your employing office will notify you if individual coverage is available. 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.

How can I get a Certificate of Group Health Plan Coverage?

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

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

Department of Defense/FEHB Demonstration Project

What is the Department of Defense (DoD) and FEHB Program Demonstration Project?

The National Defense Authorization Act for 1999, Public Law 105-261, established the DoD/FHEHP Demonstration Project. It allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000. DoD and OPM have set-up some special procedures to successfully implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is Eligible?

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

- You are an active or retired uniformed service member and are eligible for Medicare,
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare
- You are a qualified former spouse of an active or retired uniformed service member, and
- You live in one of the eight geographic demonstration areas.

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

Where Are The Demonstration Areas?

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

When Can I Join?

Your first opportunity to enroll will be during the 1999 Open Season, November 8, 1999, through December 13, 1999. Your coverage will begin January 1, 2000. DoD has set-up Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877-DOB-FEHB (1-877-363-3342).

You may select coverage for yourself (self-only) or for you and your family (self and family) during 1999, 2000, and 2001 Open Seasons. Your coverage will begin January 1 of the year following the open Season that you enrolled.

If you become eligible for the DoD/FEHBP Demonstration Project outside the Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including “The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project,” on the OPM web site at www.opm.gov.

Am I eligible for Temporary Continuation of Coverage (TCC)?

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

Department of Defense/FEHB Demonstration Project *continued*

Am I eligible for Temporary Continuation of Coverage (TCC)? *continued*

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

Do I have the 31-Day Extension and Right To Convert?

These provisions do not apply to the DoD/FEHBP Demonstration Project.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800-466-8397 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Texas Health Choice, L.C. – 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

Benefits		Plan pays/provides	Page
Inpatient Care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing.	13
	Extended Care	All necessary services, up to 100 days each calendar year. **You pay** nothing	13
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per calendar year. **You pay** nothing	16
	Serious Mental Illness	Treatment for serious mental illness is provided for up to 45 days per calendar year. **You pay** nothing	17
	Substance Abuse	Treatment for substance abuse in a chemical dependency treatment center. Treatment for medical aspects and detoxification provided under hospital benefits. **You pay** nothing for 30 inpatient days per calendar year	17
Outpatient Care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and x-rays; complete maternity care. **You pay** $10 per office visit. **You pay** nothing for laboratory and x-rays, childhood immunizations, prenatal and postnatal office visits and nothing per house call by doctor.	
	Home Health Care	All necessary visits by nurses and health aids. **You pay** nothing	12
	Mental Conditions	Up to 40 visits per calendar year. **You pay** $10 per visit	16
	Serious Mental Illness	Treatment for serious mental illness is provided for up to 60 outpatient visits per calendar year. **You pay** $10	16
	Substance Abuse	Treatment for substance abuse in a chemical dependency treatment center. Treatment for medical aspects and detoxification provided under hospital benefits. No dollar or day limit. **You pay** $10 for each covered visit	17
Emergency Care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** $100 for an emergency room visit (waived if admitted to a hospital) for each emergency visit to a non-Plan provider, and copays (other than office visit copays) which would have been paid to the Plan and any charges for services that are not covered benefits of this Plan	14-15

Summary of Benefits for Texas Health Choice, L.C. – 2000 *continued*

Prescription Drugs	Drugs prescribed by a Plan doctor or participating dentist and obtained at a Plan pharmacy or through mail order services. **You pay** copays for formulary drugs and a coinsurance for non-formulary drugs 17-18
Dental Care	Preventive and diagnostic services. **You pay** copays for these services 18
Vision Care	One refraction annually, including eyeglass lens prescription. **You pay** $10 per visit 18
Out-of-Pocket Limit	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $600 per Self Only or $1,200 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include prescription drugs, inpatient mental conditions benefits, dental services, durable medical equipment benefit's, or orthopedic and prosthetic device benefits. 3

2000 Rate Information for TEXAS HEALTH CHOICE

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

Postal rates apply to most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees" RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Houston/Beaumont areas									
Self Only	**2T1**	**$51.44**	**$17.14**	**$111.44**	**$37.15**	**$60.86**	**$7.72**	**$60.86**	**$7.72**
Self and Family	**2T2**	**$131.66**	**$43.89**	**$285.27**	**$95.09**	**$155.80**	**$19.75**	**$155.80**	**$19.75**
Dallas/Ft. Worth areas,									
Self Only	**UK1**	**$60.90**	**$20.30**	**$131.95**	**$43.98**	**$72.07**	**$9.13**	**$72.07**	**$9.13**
Self and Family	**UK2**	**$155.88**	**$51.96**	**$337.74**	**$112.58**	**$184.46**	**$23.38**	**$184.46**	**$23.38**