Back to TOC

FIRSTCARE
Southwest Health Alliances

FIRSTCARE 2003

http://www.firstcare.com

A Health Maintenance Organization

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

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See pages 6-7 for requirements.

West Texas

Enrollment codes for this Plan:

- **CK1 Self Only**
- **CK2 Self and Family**

Central Texas

Enrollment codes for this Plan:

- **6U1 Self Only**
- **6U2 Self and Family**

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

RI 73-496

Back to TOC

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Back to TOC

Notice of the Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

Back to TOC

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Back to TOC

Table of Contents

Back to TOC

Introduction

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. The address for FIRSTCARE administrative offices is:

SHA, L.L.C. dba FIRSTCARE
12940 N. Highway 183
Austin, Texas 78750

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on pages 8-9. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means 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 us 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 20415-3650.

Stop Health Care Fraud!

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

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

Back to TOC

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 800/884-4901 and explain the situation.
    - If we do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:

The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
    - you can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits to try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Back to TOC

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of our most recent provider directory.

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You 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 our networks, providers, our facilities, and us. 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.

If you want more information about us, call 800/884-4901, or write to 12940 N. Highway 183, Austin, Texas 78750. You may also contact us by fax at 512/257-6037 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.

Back to TOC

In **Central Texas**, 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.

Back to TOC

Section 2. How we change for 2003

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

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the Do/DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium for Enrollment Code CK will increase by 26.1% for Self Only or 27.8% for Self and Family. Enrollment Code 6U will decrease 19.0% for Self Only or 19.2% for Self and Family.
- We now show "non-formulary" prescription drugs as "non-Preferred" prescription drugs. The following copayments apply:
  - Retail pharmacy copayment for non-Preferred Name Brand drug increases from $30 to $40 per unit or refill.
  - Mail order pharmacy copayment for non-Preferred Name Brand drug increases from $60 to $80 for a 90 day supply.
- Insulin and other diabetic treatment medication copays change as follows:
  - Retail Pharmacy (up to a 30 day supply):
    - Generic drug copay will be $10 per unit or refill;
    - Preferred Name Brand drug copay will be $20 per unit or refill;
    - Non-Preferred Name Brand drug copay will be $40 per unit or refill;
    - When a Generic drug is available, the copay will be $10 plus the price difference in the cost of the Preferred Name Brand drug over the Generic drug.
  - Mail Order Pharmacy (up to a 90 day supply):
    - Generic drug copay will be $20 per unit or refill;
    - Preferred Name Brand drug copay will be $40 per unit or refill;
    - Non-Preferred Name Brand drug copay will be $80 per unit or refill;
    - When a Generic drug is available, the copay will be $20 plus the price difference in the cost of the Preferred Name Brand drug over the Generic drug.
- The cost of diabetic equipment and supplies changes from 20% of all charges to 20% coinsurance and applies a 30-day limit to diabetic supplies.
- Growth hormone is now covered in the cost of growth hormone therapy at no charge. See Treatment Therapy, Section 5(a).

Back to TOC

- Infertility drugs are not covered.
- The primary care physician office visit copay increases from $10 to $15 per office visit.
- The specialist office visit copay increases from $15 to $25 per office visit.
- The physician home visit copay increases from $20 to $25 per visit.
- The emergency care urgent care center copay increases from $25 to $40 per visit, in or outside the service area.
- The emergency care outpatient hospital copay will increase from $75 to $100 per visit, in or outside the service area.
- A $100 copay per inpatient hospital admission now applies.
- A $50 copay per visit for outpatient surgery now applies.

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 or write to us at 12940 N. Highway 183, Austin, Texas 78750. You may also request replacement cards through our website at www.firstcare.com.

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 775 primary care physicians, 1280 Specialists, 62 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, or on our website at www.firstcare.com.

- **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 at www.firstcare.com.

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. Remember, you must choose your OB/GYN and notify the Plan of your choice prior to your first visit.

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.

Back to TOC

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.

Back to TOC

- **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 Services 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 preauthorization. Your physician must obtain preauthorization for certain services, such as outpatient surgery, inpatient hospital admissions, growth hormone therapy (GHT) in children with documented growth hormone deficiency disease, certain prescription drugs, and durable medical equipment (DME) e.g., oxygen and monitoring devices.

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!

Back to TOC

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 $15 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 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 catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for prescription drug and DME.

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

Back to TOC

Section 5. Benefits – OVERVIEW

(See pages 8-9 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.

Back to TOC

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	$15 per office visit to your primary care physician $25 per office visit to a specialist
• In an urgent care center	$25 per visit
• During a hospital stay • In a skilled nursing facility	Nothing Nothing
• Office medical consultations • Second surgical opinion	$15 per office visit to your primary care physician $25 per office visit to a specialist
• At home	$25 per visit
Lab, X-ray and other diagnostic tests	
Such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Back to TOC

Preventive care, adult	You pay
Routine screenings, such as: • Fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides) – once every 3 years for adults age 20 or over; and • Colorectal Cancer Screening, including: - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Colonoscopy – once every 10 years at age 50; or - Double contrast barium enema (DCBE) – once every 5-10 years at age 50 • Routine 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. • Annual influenza vaccines • Pneumococcal vaccine, age 65 and over • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • 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, flight clearance, sports or legal proceedings	*All charges*

Back to TOC

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics and those required by the Texas Department of Health	Nothing
• Well-child care charges for routine examinations, immunizations and care (through age 22).	$15 per office visit to your primary care physician; $25 to a specialist.
• 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 12 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 for pre- and post-natal care; $100 inpatient copay applies.
• *Not covered: Sonograms to determine fetal sex*	*All charges*

Back to TOC

Family planning	You pay
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures, Section 5 (b)) • 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. We will not refund any portion of the coinsurance if the implanted time-release medication is removed before the end of its expected life.	$15 per visit to your primary care physician $25 per visit to a specialist 20% of charges for all services and procedures related to Family Planning, in addition to the appropriate office visit copayment, if applicable.
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) • Lab and x-ray services	50% of charges
Not Covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization* - *Fertility drugs* - *Embryo transfer, gamete GIFT and zygote ZIFT* - *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	
• Testing and treatment	$25 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*

Back to TOC

Treatment therapies	You pay
• 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	$15 copay per primary care office visit; $25 copay per specialist office visit; $50 copay per outpatient facility visit or $100 copay per inpatient admission.
• Growth hormone therapy (GHT) for children with growth hormone deficiency disease. We will only cover GHT and growth hormone when we authorize the treatment of documented growth hormone deficiency in children. We will ask your physician to submit information that establishes that the GHT is medically necessary. Your physician needs to authorize GHT before treatment begins; 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.	Nothing
Physical and occupational therapies	
• Physical therapy and occupational therapy services for 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. • 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.	$25 per office visit; $50 per outpatient visit; included in the $100 inpatient admission copay.
Not Covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges*

Back to TOC

Speech therapy	You pay
• Speech therapy services provided by a speech therapist	$25 per office visit; $50 outpatient visit; included in the $100 inpatient admission copay.
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*)	$15 per office visit to your primary care physician $25 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*

Back to TOC

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.	$15 per visit to your primary care physician $25 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 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 repairs, maintenance or replacements, except for breast prostheses; and standard replacements needed because of physical growth by dependents under 18 years of age.* • *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*

Orthopedic and prosthetic devices continued on next page

Back to TOC

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 Note: DME must be pre-authorized, unless it is provided by your physician's office.	20% of charges
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.*	*All charges*

Durable Medical Equipment continued on next page

Back to TOC

Durable medical equipment (DME) *(Continued)*	**You pay**
• *Hygienic or self help items or equipment.* • *Sports cords.* • *TENS units.* • *Repair or replacement resulting from misuse or abuse*	*All charges*
Diabetic Equipment and Supplies	
• Equipment 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 - Injection aids - Insulin cartridges - Infusion sets • 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% co-insurance
• *Note: Supplies limited to 30 day supply*	*All charges*

Back to TOC

Home health services	You pay
• 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.	$15 per office visit to your primary care physician $25 per office visit to a specialist

Back to TOC

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 PREAUTHORIZATION OF SOME SURGICAL PROCEDURES. Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.
- 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	$15 when performed in primary care office; $25 when performed in specialist office $50 when performed in outpatient surgical facility Included in the $100 inpatient admission copay
• Voluntary sterilization (e.g. tubal ligation, vasectomy)	20% of charges

Surgical procedures continued on next page

Back to TOC

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.	$15 when performed in primary care office; $25 when performed in specialist office $50 when performed in outpatient surgical facility Included in the $100 inpatient admission copay
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 continued on next page

Back to TOC

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), 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.	$15 when performed in primary care office; $25 when performed in specialist office $50 when performed in outpatient surgical facility Included in the $100 inpatient admission copay
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; testicular, mediastinal;, retroperitoneal and ovarian germ cell tumors • Autologous tandem transplants for testicular cancer and other germ cells 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

Back to TOC

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

Back to TOC

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.	$100 per admission

Inpatient Hospital continued on next page

Back to TOC

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.	$50 per visit
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.	$100 per admission
Not Covered: • *Custodial care* • *Rest cures* • *Domiciliary or convalescent care*	*All charges*

Back to TOC

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	$15 per office visit to your primary care physician $25 per office visit to a specialist
• Emergency care at an urgent care center	$40 per visit
• Emergency care as an outpatient, including doctors' services	$100 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	$25 per office visit, plus all amounts over the Usual, Customary and Reasonable (UCR) charges for the services rendered.
• Emergency care at an urgent care center	$40 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$100 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.

Emergency outside our service area continued next page

Back to TOC

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

Back to TOC

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	$25 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.	$100 per admission
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 your treatment plan and follow all of our network authorization processes. These include:

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 Central Texas area – 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 is Express Scripts 888/202-4560.

- **We use a Preferred Drug List (PDL)**

  Our Preferred Drug List 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 Preferred Drug List to take advantage of the best combination of safety, effectiveness and cost savings. Drugs not included in the PDL are called "non-Preferred" drugs and you must pay a higher copayment for these drugs. If you need to order a Preferred Drug List or have any questions, please call our Customer Services Department at 800/884-4901 or visit our website at www.firstcare.com

- **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.

  If you or your physician request a Name Brand drug when a Generic equivalent is available, you will be responsible for the Generic Drug Copayment plus the difference between the cost of the Generic Drug and the cost of the Name Brand 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 those listed 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. • Insulin, insulin analogs, and glucagon emergency kits	*Retail Pharmacy*, for a 30-day supply per prescription unit or refill: A $10 copay for generic drugs; A $20 copay for Preferred Name Brand drugs when a generic equivalent is not available; A $40 copay for non-Preferred drugs; and A $10 copay for Preferred Name Brand drugs when a generic equivalent is available, plus the difference between the cost of the generic drug and the cost of the Preferred 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 Preferred Name Brand drugs when a generic equivalent is not available; A $80 copay for non-Preferred drugs; and A $20 copay for Preferred Name Brand drugs when a generic equivalent is available, plus the difference between the cost of the generic drug and the cost of the Preferred Name Brand drug.

Covered medications and supplies continued on the next page

Back to TOC

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	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. • Prescribing Generic drugs is encouraged. Prescribing Preferred Name Brand drugs is encouraged over non-Preferred Name Brand drugs. • A Generic (1st-tier) or Preferred Name Brand (2nd-tier) drug may not always be available or appropriate to treat a condition. In that case, a non-Preferred Name Brand drug is covered at the non-Preferred (3rd-tier) Copayment when used to treat a covered medical condition. • A non-Preferred drug is a prescription medication that is not in the Preferred Drug List. Non-Preferred drugs require a higher copayment. • Prescriptions will not be refilled until 70% of the prescription has been used.	
Not Covered: • *Drugs and supplies for cosmetic purposes, including medications such as Lamisil or Sporanox for the treatment of uncomplicated nail fungus, and drugs for hair growth or removal.* • *Vitamins, and nutritional substances that can be purchased without a prescription, except for pre-natal vitamins* • *Nonprescription medicines, except for the treatment of diabetes* • *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* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Smoking cessation drugs and medication, including nicotine patches*	*All Charges*

Covered medications and supplies continued on the next page

Back to TOC

Covered medications and supplies *(Continued)*	**You pay**
Not Covered (continued): • *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*

Back to TOC

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.

Back to TOC

Section 5 (h). Dental 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:

- 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.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5 (c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.

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

IMPORTANT

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

Back to TOC

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** and we agree, as discussed under *What Services Require Our Prior Approval* on page 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.
- Services, drugs, supplies you receive without charge while in active military service.

Back to TOC

Section 7. Filing a claim for Medical, Hospital and Drug benefits

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 services you receive outside of the service area -- 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 N Highway 183
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.

Back to TOC

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 preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to our Complaints and Appeals Department at 12940 N. Highway 183, Austin 78750; 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.

Back to TOC

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 more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year, in which you received the disputed services, drugs, or supplies or from the year in which you were denied preauthorization. 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 preauthorization/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 preauthorization/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 may call OPM's Health Benefits Contracts Division 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Back to TOC

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage 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,

Back to TOC

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.

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.

(Primary payer chart begins on next page.)

Back to TOC

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 re-employed 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 12940 N. Highway 183, Austin, Texas 78750 so we can determine the secondary coverage.

Back to TOC

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans 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 and CHAMPVA

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program,

Back to TOC

generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

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.

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

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, 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.

Back to TOC

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.

Custodial care that lasts 90 days or more is sometimes known as Long term care.

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

Back to TOC

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.

Back to TOC

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 your FEHB coverage. These materials tell you:

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

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

Types of coverage available for you and your family

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

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

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

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

Back to TOC

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- if you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- if you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact your employing office for further information.

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.

Back to TOC

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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

- **Temporary continuation of coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your 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 RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (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.

Back to TOC

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

Back to TOC

Index

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

Back to TOC

Summary of benefits for FIRSTCARE – 2003

- **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: $15 primary care; $25 specialist	15
Services provided by a hospital: • Inpatient ..... • Outpatient.....	 $100 per admission $50 per visit	 29 30
Emergency benefits: • In-area ..... • Out-of-area.....	$100 per emergency room visit; waived if admitted $100 per emergency room visit; waived if admitted.	 32 32
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 Preferred Name Brand drugs when a generic is not available; $40 copay for non-Preferred drugs; and $10 copay for Preferred Name Brand drugs when a generic drug is available, plus difference in cost between the generic and Preferred Name Brand drugs. **Mail Order Pharmacy:** $20 copay for generic drugs; $40 copay for Preferred Name Brand drugs when a generic is not available; $80 copay for non-Preferred drugs; and $20 copay for Preferred Name Brand drugs when a generic drug is available, plus difference in cost between the generic and Preferred Name Brand drugs.	36
Dental Care.....	No benefit.	41
Vision Care.....	Nothing during office visit.	20
Special features: Services for deaf and hearing impaired; Centers of excellence for transplants/heart surgery/etc.		40
Protection against catastrophic costs (your catastrophic protection 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

Back to TOC

2003 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
Central Texas							
Self Only	6U1	$92.66	$30.89	$200.77	$66.92	$109.65	$13.90
Self and Family	6U2	$199.06	$66.35	$431.30	$143.76	$235.55	$29.86
West Texas							
Self Only	CK1	$109.30	$67.21	$236.82	$145.62	$129.03	$47.48
Self and Family	CK2	$249.62	$129.51	$540.84	$280.61	$294.70	$84.43