

# FIRSTCARE

<http://www.firstcare.com>

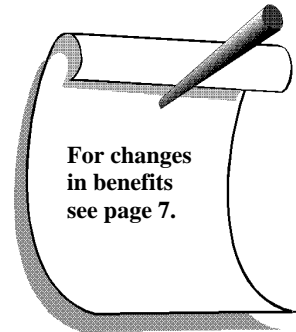


## 2006

## A Health Maintenance Organization

**Serving:** Much of the West Texas and Central Texas areas.

**Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.**



### West Texas

**Enrollment code for this Plan:**

- CK1 – Self Only
- CK2 – Self and Family

### Central Texas

**Enrollment code for this Plan:**

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

Authorized for distribution by the:



**United States  
Office of Personnel Management**

Center for  
Retirement and Insurance Services  
<http://www.opm.gov/insure>

**RI 73-496**

## Notice of the United States 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 United States 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 Government Accountability Office when conducting audits.

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

- For Government health care 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.

For more information on exercising your rights set out in this notice, look at [www.opm.gov/insure](http://www.opm.gov/insure) on the Web. You may also call 202-606-0745 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  
United States 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 United States 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 are effective April 14, 2003.

## **Important Notice from FIRSTCARE About Our Prescription Drug Coverage and Medicare**

OPM has determined that FIRSTCARE prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

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### **Please be advised**

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If you lose or drop our coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

#### **Medicare's Low Income Benefits**

*For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).*

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

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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## Introduction

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This brochure describes the benefits of under our contract (CS 2321) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for FIRSTCARE administrative offices is:

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 exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self 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, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 7. Rates are shown at the end of this brochure.

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## Plain Language

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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.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean 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](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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

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

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

- 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:**

**United States Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street NW Room 6400  
Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child 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, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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## Preventing medical mistakes

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An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

**1. Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

### **3. Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

### **4. Talk to your doctor about which hospital is best for your health needs.**

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

### **5. Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery?
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- [www.ahrq.gov/consumer/pathqpack.htm](http://www.ahrq.gov/consumer/pathqpack.htm). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- [www.talkaboutrx.org/consumer.html](http://www.talkaboutrx.org/consumer.html). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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## Section 1 Facts about this HMO plan

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

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

### How we pay providers

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

### Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site ([www.opm.gov/insure](http://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 877-878-8422 or visit our Web site at [www.firstcare.com](http://www.firstcare.com).

### Service Area

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

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

In **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 benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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

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## Section 2 How we change for 2006

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

### Changes to this Plan

- Your share of the non-Postal premium for Enrollment Code CK will decrease by 28.4% for Self Only or 31.4% for Self and Family. Enrollment Code 6U will increase by 1% for Self Only and 1.1% for Self and Family.
- The specialist office visit copay increases from \$20 to \$40 per visit.
- The physician home visit copay increases from \$20 to \$40 per visit.
- The inpatient admission copay increases to \$200 per day up to a maximum of \$1,000 per admission for contracted facilities outside our service area. The copay for inpatient admissions within our service area remains at \$100 per day up to a maximum of \$500 per admission.
- The mail order copay for prescription drugs increases from two (2) times the retail copay to three (3) times the retail copay.

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## Section 3 How you get care

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### Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-884-4901 or write to us at 12940 N. Highway 183, Austin, Texas 78750. You may also request replacement cards through our Web site: [www.firstcare.com](http://www.firstcare.com).

### Where you get covered care

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

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site at [www.firstcare.com](http://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 Web site at [www.firstcare.com](http://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 has direct access to an in-plan obstetrician/gynecologist (OB/GYN). 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.

- **Primary care**

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

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us at 800-884-4901. We will help you select a new one.

- **Specialty care**

Your primary care physician can refer you to a specialist for needed care. However, you may see an obstetrician/gynecologist (OB/GYN), in-network specialist, or seek emergency care without a referral. Your primary care physician may 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 and must obtain an authorization from FIRSTCARE in advance.

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

- 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 and 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 program Plan; or
  - Reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Customer 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 92<sup>nd</sup> day after you become a member of this Plan, whichever happens first.

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

## **How to get approval for...**

- **Your hospital stay**

If you are admitted to the hospital on an emergency basis, be sure to tell the hospital 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. Once we are notified, we will review your case to make sure that your continued stay is medically necessary and arrange for continuing care needs.

- **How to preauthorize an admission**

For elective hospital admissions, your physician must contact our preauthorization department to get preauthorization of hospital stays prior to your admission date. Before giving approval, we will consider if the service is covered, medically necessary, and follows generally accepted medical practice.

- **Maternity care**

Once you have seen your physician and it is determined that you are pregnant, your physician must contact our preauthorization department to get preauthorization of your hospital stay for your delivery.

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

If preauthorization is required for a service and it has not been obtained, your services will be denied for late notification if you fail to notify us in a timely manner or no notification if you fail to notify us at all. When services are denied, you are financially responsible for the care you received.

**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, treatment for morbid obesity, 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!

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## Section 4 Your cost for covered services

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

### **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 \$20 per office visit and when you go in the hospital, you pay \$100 per day up to a maximum of \$500 per admission.

### **Deductible**

This plan does not have a deductible.

### **Coinsurance**

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

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

### **Your catastrophic protection out-of-pocket maximum**

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 for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services: prescription drugs and durable medical equipment (DME).

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

### **Carryover**

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

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## Section 5 Benefits

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

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## Section 5 Benefits Overview

Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about our benefits, contact us at 800-884-4901 or at our Web site at [www.firstcare.com](http://www.firstcare.com).

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

**Important things you should keep in mind about these benefits:**

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

Benefit Description	You pay
<b>Diagnostic and treatment services</b>	
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician's office</li> </ul>	\$20 per visit to your primary care physician \$40 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> <li>• In an urgent care center</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> </ul>	Included in the applicable copay depending on place of service: \$200 copay per outpatient facility visit; or included in inpatient copayment of \$100 per day up to \$500 maximum copay per admission.
<ul style="list-style-type: none"> <li>• Second surgical opinion</li> <li>• Office medical consultations</li> </ul>	\$40 per visit
At home	\$40 per visit

*Diagnostic and treatment services – continued on next page.*

<b>Lab, X-ray and other diagnostic tests</b>	
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>• CAT Scans/MRI</li> </ul>	\$100 per procedure
<b>Preventive care, adult</b>	
Routine physical every year which includes: Routine screenings, such as: <ul style="list-style-type: none"> <li>• Total Blood Cholesterol</li> <li>• Colorectal Cancer Screening, including               <ul style="list-style-type: none"> <li>- Fecal occult blood test</li> <li>- Sigmoidoscopy, screening – every five years starting at age 50</li> <li>- Double contrast barium enema – every five years starting at age 50</li> <li>- Colonoscopy screening – every ten years starting at age 50</li> </ul> </li> </ul>	\$20 per PCP visit \$40 per specialist visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older  Routine Pap test	Nothing if you receive these services during your office visit
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• From age 40 through 64, one every calendar year</li> <li>• At age 65 and older, one every two consecutive calendar years</li> </ul>	Nothing if you receive these services during your office visit
Routine immunizations, such as: <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza vaccine, annually</li> <li>• Pneumococcal vaccine, age 65 and older</li> </ul>	Nothing if you receive these services during your office visit
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>

<b>Preventive care, children</b>	
<ul style="list-style-type: none"> <li>Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>Well-child care charges for routine examinations, immunizations and care (up to age 22)</li> </ul>	\$20 per PCP visit \$40 per specialist visit
<ul style="list-style-type: none"> <li>Examinations, such as:               <ul style="list-style-type: none"> <li>Eye exams through age 17 to determine the need for vision correction</li> <li>Hearing exams through age 17 to determine the need for hearing correction</li> <li>Examinations done on the day of immunizations (up to age 22)</li> </ul> </li> </ul>	Nothing if you receive these services during your office visit
<b>Maternity care</b>	
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> <li>Prenatal care</li> <li>Delivery</li> <li>Postnatal care</li> </ul>	Nothing for pre- and post-natal care; inpatient copay of \$100 per day up to \$500 maximum copay per admission applies.
Note: Here are some things to keep in mind: <ul style="list-style-type: none"> <li>Your physician will preauthorize your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby.</li> <li>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.</li> <li>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.</li> <li>We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</li> </ul>	
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	All charges.
<b>Family planning</b>	
A range of voluntary family planning services, limited to: <ul style="list-style-type: none"> <li>Voluntary sterilization (See Surgical procedures Section 5 (b))</li> <li>Surgically implanted contraceptives</li> <li>Injectable contraceptive drugs (such as Depo provera)</li> <li>Intrauterine devices (IUDs)</li> <li>Diaphragms</li> </ul> Note: We cover oral contraceptives under the prescription drug benefit.	\$20 per office visit  20% of charges for all services and procedures related to Family Planning, in addition to the appropriate office visit copayment, if applicable.

<b>Family planning (continued)</b>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Reversal of voluntary surgical sterilization</li> <li>• Genetic counseling.</li> </ul>	All charges.
<b>Infertility services</b>	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>- intravaginal insemination (IVI)</li> <li>- intracervical insemination (ICI)</li> <li>- intrauterine insemination (IUI)</li> </ul> </li> <li>• Lab and x-ray services</li> </ul>	50% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> <li>- in vitro fertilization</li> <li>- Fertility drugs</li> <li>- embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</li> </ul> </li> <li>• Services and supplies related to ART procedures</li> <li>• Surrogate parenting fees</li> <li>• Cost of donor sperm</li> <li>• Cost of donor egg.</li> </ul>	All charges.
<b>Allergy care</b>	
Testing and treatment	\$20 per PCP visit; \$40 per specialist visit
Allergy injections, when administered without an office visit.	50% of charges
Allergy serum	Nothing
<i>Not covered: provocative food testing and sublingual allergy desensitization</i>	All charges.

Treatment therapies	You pay
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$20 per PCP visit; \$40 per specialist visit; \$200 copay per outpatient facility visit; or included in inpatient copayment of \$100 per day up to \$500 maximum copay per admission.</p>
Physical and occupational therapies	
<p>Physical therapy and occupational therapy services of each of the following:</p> <ul style="list-style-type: none"> <li>• qualified physical therapists and</li> <li>• occupational therapists</li> </ul> <p>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.</p> <p>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.</p> <p>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.</p>	<p>\$40 per visit; \$200 copay per outpatient facility visit; or included in inpatient copay of \$100 per day up to \$500 maximum copay per admission.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Long-term rehabilitative therapy</i></li> <li>• <i>Exercise programs</i></li> <li>• <i>Aqua therapy, unless associated with a physical therapy modality provided by a licensed physical therapist</i></li> </ul>	<p>All charges.</p>

Speech therapy	You pay
Speech therapy services provided by a speech therapist	\$40 per visit; \$200 copay per outpatient facility visit; or included in inpatient copay of \$100 per day up to \$500 maximum copay per admission.
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> <li>• First hearing aid and testing only when necessitated by accidental injury</li> <li>• Hearing testing for children through age 17, which include; (see <i>Preventive care, children</i>)</li> <li>• Hearing aids</li> </ul> <p>Note: Must be medically necessary as determined by a Plan physician, authorized in advance by the Plan, and obtained for a Plan provider.</p>	<p>\$20 per PCP visit; \$40 per specialist visit</p> <p>Nothing up to Plan maximum of \$500 per ear once every 36 months; all charges over \$500 per ear.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>All other hearing testing</i></li> <li>• <i>Repair or replacement of hearing aids due to normal wear and tear and loss or damage</i></li> </ul>	All charges.
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> <li>• Eye screenings, annually, for children through age 18 to determine vision loss (See <i>Preventive care, children</i>)</li> <li>• Eye screenings, biennially, for members age 19 and older to determine vision loss (See <i>Preventive care, adult</i>)</li> </ul>	Nothing if you receive these services during your primary care physician office visit.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Eyeglasses, frames, or contact lenses (including the fitting of contact lenses), except as necessary for the first pair of corrective lenses following cataract removal</i></li> <li>• <i>Eye exercises and orthoptics</i></li> <li>• <i>Radial keratotomy and other refractive surgery</i></li> <li>• <i>Refractions, including lens prescriptions, to determine the need for glasses or contacts</i></li> </ul>	All charges.

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	\$20 per PCP visit; \$40 per specialist visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>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</i></li> <li>• <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></li> </ul>	All charges.
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> <li>• Foot orthotics</li> <li>• Podiatric appliances for the prevention of complications associated with diabetes.</li> </ul>	20% of all charges
<ul style="list-style-type: none"> <li>• 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.</li> </ul>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li>• <i>Prosthetic repairs, maintenance or replacements, except for breast prostheses; and standard replacements needed because of physical growth by dependents under 18 years of age</i></li> <li>• <i>Cochlear implanted device</i></li> <li>• <i>Wigs or prosthetic hair</i></li> <li>• <i>Implanted neurological stimulators, including but not limited to spinal or dorsal column stimulators for relief of pain, Parkinson's movement disorders or seizures.</i></li> </ul>	All charges.

<b>Durable medical equipment (DME)</b>	<b>You pay</b>
<p>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:</p> <ul style="list-style-type: none"> <li>• Manual hospital beds;</li> <li>• Manual wheelchairs;</li> <li>• Crutches;</li> <li>• Canes;</li> <li>• Walkers;</li> <li>• Braces (limb or back only);</li> <li>• Traction devices;</li> <li>• Nebulizers;</li> <li>• Indwelling urinary catheters;</li> <li>• C-PAP monitoring device (when there is a diagnosis of documented obstructive sleep apnea);</li> <li>• Oxygen, oxygen concentrators, rental of equipment for administration of oxygen, and mechanical equipment necessary for the treatment of chronic or acute respiratory failure;</li> </ul> <p>Note: Oxygen and equipment must be prescribed and directed by a Plan provider, and approved in advance by the Plan.</p> <ul style="list-style-type: none"> <li>• Monitoring devices, such as apnea monitors and uterine monitors for use in the home, when prescribed and directed by a Plan provider;</li> <li>• Ostomy supplies;</li> <li>• Sterile dressing change kits, i.e., tracheostomy suction and dressing kits, and central line dressing kits.</li> </ul> <p>Note: Call us at 800-884-4901 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>20% of charges limited to \$4,000 maximum benefit per year</p>

*DME – continued on next page*

<b>Durable medical equipment (DME) (continued)</b>	<b>You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Motorized, deluxe, and custom wheelchairs and hospital beds; auto tilt chairs</i></li> <li>• <i>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.</i></li> <li>• <i>Environmental control equipment, such as air conditioners, purifiers, humidifiers, de-humidifiers, electrostatic machines and heat lamps</i></li> <li>• <i>Institutional equipment, such as fluidized beds and diathermy machines</i></li> <li>• <i>Consumable medical supplies, such as over-the-counter bandages, dressings and other disposable supplies and skin preparations.</i></li> <li>• <i>Foam cervical collars</i></li> <li>• <i>Stethoscopes, sphygmomanometers, reading oximeters</i></li> <li>• <i>Hygienic or self help items or equipment</i></li> <li>• <i>Sports cords</i></li> <li>• <i>TENS units</i></li> <li>• <i>Repair or replacement resulting from misuse or abuse</i></li> </ul>	<p>All charges.</p>

<b>Diabetic Equipment and Supplies</b>	
<p>Equipment as follows:</p> <ul style="list-style-type: none"> <li>• Blood glucose monitors, including monitors designed to be used by blind individuals</li> <li>• Insulin pumps and associated appurtenances</li> <li>• Insulin infusion devices</li> <li>• Podiatric appliances for the prevention of complications associated with diabetes</li> <li>• Injection aids</li> <li>• Insulin cartridges</li> <li>• Infusion sets</li> </ul> <p>Supplies including:</p> <ul style="list-style-type: none"> <li>• Test strips for blood glucose monitors</li> <li>• Visual reading and urine test strips</li> <li>• Lancets and lancet devices</li> <li>• Injection aids</li> <li>• Syringes</li> <li>• Needles</li> <li>• Glucose test tablets and test tape</li> <li>• Benedict's solution or equivalent</li> <li>• Acetone test tablets</li> </ul> <p>Note: Supplies limited to 30 day supply</p>	<p>20% co-insurance</p>
<b>Home health services</b>	
<ul style="list-style-type: none"> <li>• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.</li> <li>• Services include oxygen therapy, intravenous therapy and medications.</li> </ul>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li>• <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i></li> </ul>	<p><i>All charges.</i></p>

<b>Chiropractic</b>	
No benefit	All charges
<b>Alternative treatments</b>	<b>You pay</b>
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
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Naturopathic services</i></li> <li>• <i>Hypnotherapy</i></li> <li>• <i>Biofeedback</i></li> <li>• <i>Acupuncture</i></li> <li>• <i>Equine or Hippo therapy</i></li> <li>• <i>Massage therapy, unless associated with a physical therapy modality provided by a licensed physical therapist</i></li> </ul>	All charges.
<b>Educational classes and programs</b>	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>• Diabetes self management training, including counseling and use of diabetic equipment and supplies</li> <li>• Nutritional counseling for morbid obesity</li> </ul>	\$20 per PCP visit; \$40 per specialist visit

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

**Important things you should keep in mind about these benefits:**

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

Benefit Description	You pay
<b>Surgical procedures</b>	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see <i>Reconstructive surgery</i>)</li> <li>• Surgical treatment of morbid obesity (bariatric surgery)</li> </ul> <p>“Morbid Obesity” is defined as an abnormal increase of fat sufficient to prevent normal activity or physiologic function, or to cause the onset of a pathologic condition. FIRSTCARE will consider Bariatric Surgery for Morbid Obesity medically necessary when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> <li>- Body Mass Index(BMI) &gt; 40 kg/meter; or &gt; 35 kg/meter with the any of the following co-morbidities: coronary artery disease, type 2 diabetes, documented obstructive sleep apnea, or medically refractive hypertension (blood pressure systolic &gt;140 and/or diastolic &gt;90 despite optimal medical management); <b>AND</b></li> <li>- Member is &gt;18 years of age or has documentation of bone growth completion; <b>AND</b></li> </ul>	<p>\$50 when performed in a Plan providers’ office, or</p> <p>\$200 when performed in outpatient surgical facility, or</p> <p>Included in the inpatient admission copay of \$100 per day up to \$500 maximum copay per admission at a contracted facility within our service area, or</p> <p>Included in the inpatient admission copay of \$200 per day up to \$1,000 maximum copay per admission at a contracted facility outside of our service area</p>

<b>Surgical procedures</b> <i>(continued)</i>	<b>You pay</b>
<ul style="list-style-type: none"> <li>- Member has failed a medically supervised (MD, DO, or Nurse Practitioner) non-surgical weight loss program within 2 (two) years of the request for surgery. This documented program had to have been greater than 6 (six) months duration consisting of dietician consultation, low calorie diet, increased physical activity, and behavioral modification; <b>AND</b></li> <li>- Psychological evaluation by an independent licensed psychologist or psychiatrist not affiliated with the surgical group.</li> <li>- Covered procedures include Roux-en-Y Gastric Bypass (open or laparoscopic), Vertical Banded Gastroplasty (VGB) and Laparoscopic Adjustable Silicone Gastric Banding (LASBG).</li> <li>• Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information</li> <li>• Voluntary sterilization (e.g., tubal ligation, vasectomy)</li> <li>• Treatment of burns</li> </ul> <p>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.</p>	<p>\$50 when performed in a Plan providers’ office, or</p> <p>\$200 when performed in outpatient surgical facility, or</p> <p>Included in the inpatient admission copay of \$100 per day up to \$500 maximum copay per admission at a contracted facility within our service area, or</p> <p>Included in the inpatient admission copay of \$200 per day up to \$1,000 maximum copay per admission at a contracted facility outside of our service area</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Any surgical procedures related to snoring and sleep apnea</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>	<p>All charges.</p>
<b>Reconstructive surgery</b>	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>- The condition produced a major effect on the member’s appearance, and</li> <li>- The condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>- surgery to produce a symmetrical appearance of breasts;</li> <li>- treatment of any physical complications, such as lymphedemas;</li> <li>- breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>)</li> </ul> </li> </ul> <p>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.</p>	<p>\$50 when performed in a Plan providers’ office, or</p> <p>\$200 when performed in outpatient surgical facility, or</p> <p>Included in the inpatient admission copay of \$100 per day up to \$500 maximum copay per admission at a contracted facility within our service area, or</p> <p>Included in the inpatient admission copay of \$200 per day up to \$1,000 maximum copay per admission at a contracted facility outside of our service area</p>

Reconstructive surgery (continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>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</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	All charges.
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Treatment of temporomandibular joint (TMJ), including surgical and non-surgical intervention, corrective orthopedic appliances, physical therapy and other surgical procedures that do not involve the teeth or supporting structures.</li> </ul>	<p>\$50 when performed in a Plan providers' office, or</p> <p>\$200 when performed in outpatient surgical facility, or</p> <p>Included in the inpatient admission copay of \$100 per day up to \$500 maximum copay per admission at a contracted facility within our service area, or</p> <p>Included in the inpatient admission copay of \$200 per day up to \$1,000 maximum copay per admission at a contracted facility outside of our service area</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> </ul>	All charges.
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single-Double</li> <li>• Pancreas</li> <li>• Allogeneic (donor) bone marrow transplants</li> <li>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> </ul>	Nothing

Organ/tissue transplants ( <i>continued</i> )	You pay
<ul style="list-style-type: none"> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> <li>• Autologous tandem transplants for testicular tumors and other germ cell tumors</li> </ul> <p>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.</p> <p>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.</p> <p>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.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Implants of artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> </ul>	All charges.
<b>Anesthesia</b>	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	Nothing

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

### Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
<b>Inpatient hospital</b>	
Room and board, such as <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$100 per day up to \$500 maximum copay per admission at a contracted facility within our service area, or  \$200 per day up to \$1,000 maximum copay per admission at a contracted facility outside of our service area
Other hospital services and supplies, such as: <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)</li> </ul>	Nothing

*Inpatient hospital - continued on next page.*

<b>Inpatient hospital (continued)</b>	<b>You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care, rest cures, domiciliary or convalescent care</li> <li>• Non-covered facilities, such as nursing homes, schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care</li> <li>• Take-home drugs</li> </ul>	All charges.
<b>Outpatient hospital or ambulatory surgical center</b>	
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>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.</p>	\$200 per visit
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	All charges.
<b>Extended care benefits/Skilled nursing care facility benefits</b>	
<p>Extended care benefit:</p> <p>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.</p> <ul style="list-style-type: none"> <li>- Bed, board and general nursing care.</li> <li>- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.</li> </ul>	<p>\$100 per day up to \$500 maximum copay per admission at a contracted facility within our service area, or</p> <p>\$200 per day up to \$1,000 maximum copay per admission at a contracted facility outside of our service area</p>
<p>Skilled nursing facility (SNF)</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>- Custodial care</li> <li>- Rest cures</li> <li>- Domiciliary or convalescent care</li> </ul>	All charges.

<b>Hospice care</b>	
<p>We cover supportive and palliative care in the home or a hospice facility</p> <p>Services include:</p> <ul style="list-style-type: none"> <li>- Inpatient and outpatient care, and</li> <li>- Family counseling.</li> </ul> <p>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.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>- <i>Independent nursing</i></li> <li>- <i>Homemaker services</i></li> </ul>	All charges.
<b>Ambulance</b>	
Local professional ambulance service when medically appropriate	\$75 per trip

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## Section 5(d) Emergency services/accidents

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### Important things you should keep in mind about these benefits:

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

### 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.

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### 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.

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**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
<b>Emergency within our service area</b>	
<ul style="list-style-type: none"> <li>Emergency care at a doctor’s office</li> </ul>	\$20 per PCP visit; \$40 per specialist visit
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center</li> </ul>	\$40 per visit
<ul style="list-style-type: none"> <li>Emergency care as an outpatient at a hospital, including doctors’ services</li> </ul> Note: We waive the ER copay if you are admitted to the hospital	\$100 per visit
<i>Not covered: Elective care or non-emergency care</i>	All charges.
<b>Emergency outside our service area</b>	
<ul style="list-style-type: none"> <li>Emergency care at a doctor’s office</li> </ul>	\$20 per PCP visit; \$40 per specialist visit, plus all amounts over the Usual, customary and Reasonable (UCR) charges for the services rendered.
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center</li> </ul>	\$40 per visit
<ul style="list-style-type: none"> <li>Emergency care as an outpatient at a hospital, including doctors’ services</li> </ul> Note: We waive the ER copay if you are admitted to the hospital	\$100 per visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	All charges.
<b>Ambulance</b>	
Professional ambulance service, including air ambulance, when medically appropriate. Note: See 5(c) for non-emergency service.	\$75 per trip

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

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.

### Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
<b>Mental health and substance abuse benefits</b>	
<p>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.</p> <p>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.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	<p>\$40 per visit</p>
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	<p>Nothing</p>
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	<p>\$100 per day up to \$500 maximum copay per admission at a contracted facility within our service area, or</p> <p>\$200 per day up to \$1,000 maximum copay per admission at a contracted facility outside of our service area</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>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.</i></p>	<p>All charges.</p>

*Mental health and substance abuse benefits – continued on next page*

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**Mental health and substance abuse benefits** *(continued)*

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**Preauthorization** To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following 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 – MHNNet, Inc. – 800-336-2030

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

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**Limitation** We may limit your benefits if you do not obtain a treatment plan.

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## Section 5(f) Prescription drug benefits

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### Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.

**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 Drug Coverage List (DCL).** Our Drug Coverage List includes all generic drugs and a comprehensive list of 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. In order to take advantage of the best combination of safety, effectiveness and cost savings, you must use drugs included on the Drug Coverage List. Our Drug Coverage List is divided into three tiers: Tier 1: Lowest co-payment for Generic Drugs; Tier 2: Higher co-payment for Limited Listed Brand Name Drugs; and Tier 3: Higher co-payment than Tier 2 for Other Brand Name Drugs. We cover non-Drug Coverage List drugs prescribed by a plan doctor at a higher copayment. If you need to order a Drug Coverage List or have any questions, please call our Customer Services Department at 800-884-4901 or visit our website at [www.firstcare.com](http://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.
- **What you should do if you are called to active duty or in case of a national emergency.** FIRSTCARE will make special arrangements for emergency supplies of medications for our members that are called active duty or during a national emergency. For information in obtaining this supply of medication, call our Customer Services Department.

- **Some things to keep in mind about our prescription drug program:**

- A generic equivalent will be dispensed if it is available. If you or your prescriber request a Name Brand drug when a Federally approved generic drug is available, 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 Limited Listed Name Brand drugs is encouraged over Other Name Brand drugs.
- A Generic or Limited Listed Name Brand drug may not always be available or appropriate to treat a condition. In that case, another Name Brand drug is covered at the Other Name Brand Copayment when used to treat a covered medical condition.
- Injectable medications recognized by the FDA as appropriate for self-administration (referred to as “Self-Injectable” Drugs), regardless of your ability to self-administer are covered at a 25% coinsurance. This benefit does not apply to diabetic medications or allergy serum.
- Prescriptions will not be refilled until 70% of the prescription has been used.

*Prescription drug benefits begin on the next page.*

**Prescription drugs (continued)**

Benefit Description	You pay
<p><b>Covered medications and supplies</b></p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i></li> <li>• Formulas necessary for the treatment of a heritable disease, such as phenylketonuria (PKU)</li> <li>• Drugs for sexual dysfunction are subject to dosage limits set by the Plan. Contact the Plan for details.</li> <li>• Oral contraceptive drugs</li> <li>• Prescription and non-prescription oral agents for controlling blood sugar levels</li> <li>• Insulin, insulin analogs, and glucagon emergency kits</li> <li>• Growth hormone drugs for children under 18 years of age. Growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred, are covered when pre-authorized</li> </ul>	<p><i>Retail Pharmacy</i>, for a 30-day supply per prescription unit or refill:            A \$10 copay for Tier 1 generic drugs;            A \$20 copay for Tier 2 Limited Listed Name Brand drugs when a generic equivalent is not available;            A \$40 copay for Tier 3 Other Name Brand drugs</p>
<ul style="list-style-type: none"> <li>- Self-injectable drugs (except insulin and glucagons)</li> <li>- Other high-technology drugs</li> </ul>	<p>25% co-insurance</p>
<ul style="list-style-type: none"> <li>• Mail Order Pharmacy, up to a 90-day supply per prescription unit or refill.</li> </ul>	<p>A \$30 copay for Tier 1 generic drugs;            A \$60 copay for Tier 2 Limited Listed Name Brand drugs when a generic equivalent is not available;            A \$120 copay for Tier 3 Other Name Brand drugs</p>
<ul style="list-style-type: none"> <li>• Contraceptive devices, such as:               <ul style="list-style-type: none"> <li>-Diaphragms</li> <li>-Intrauterine devices (IUDs)</li> <li>-Implantable drugs, such as Norplant</li> <li>-Injectable drugs, such as Depo Provera</li> </ul> </li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Allergy syringes</li> </ul>	<p>20% of all charges</p>

*Prescription drugs – continued on next page*

Covered medications and supplies <i>(continued)</i>	You pay
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> <li>- <i>Drugs and supplies for cosmetic purposes, including medications such as Lamisil or Sporanox for the treatment of uncomplicated nail fungus, and drugs for hair loss, growth or removal.</i></li> <li>- <i>Vitamins, and nutritional substances that can be purchased without a prescription, except for pre-natal vitamins</i></li> <li>- <i>Nonprescription medicines, except for the treatment of diabetes</i></li> <li>- <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i></li> <li>- <i>Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies</i></li> <li>- <i>Medical supplies such as dressings and antiseptics</i></li> <li>- <i>Drugs to enhance athletic performance</i></li> <li>- <i>Fertility drugs</i></li> <li>- <i>Smoking cessation drugs and medication, including nicotine patches</i></li> <li>- <i>Drugs prescribed for weight loss and appetite suppressants, except for medications prescribed for morbid obesity</i></li> <li>- <i>Prescription refills in excess of the number specified by the Physician and any refill dispensed more than one year after the Physician's order</i></li> <li>- <i>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</i></li> <li>- <i>Prescriptions or refills that replace lost, stolen, spoiled, expired, spilled or are otherwise misplaced or mishandled by the Member.</i></li> </ul>	<p>All charges.</p>

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### Section 5(g) Special features

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

## Section 5(h) Dental benefits

### Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

### Accidental injury benefit

We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.

### You pay

Applicable copay depending on where services are rendered.

### Dental benefits

We have no other dental benefits.

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## Section 6 General exclusions – things we don't cover

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The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** and we agree, as discussed under *What Services Require Our Prior Approval* on page 10.

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

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## Section 7 Filing a claim for covered services

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

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

### Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility 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 the Plan’s 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.

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## Section 8 The disputed claims process

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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/prior approval.

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"><li>Write to us within 6 months from the date of our decision; and</li><li>Send your request to our Complaints and Appeals Department at 1901 West Loop 289, Suite 9, Lubbock, Texas 79407; and</li><li>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ol>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"><li>Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>Write to you and maintain our denial – go to step 4; or</li><li>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.</li></ol>
<b>3</b>	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>90 days after the date of our letter upholding our initial decision; or</li><li>120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or</li><li>120 days after we asked for additional information.</li></ul> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

## 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 precertification or prior approval. This is the only deadline that may not be extended.

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

You may not 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 Service Department at 800-844-4901 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 Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

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## Section 9 Coordinating benefits with other coverage

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### 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 or 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 four 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

### • Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don’t have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

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

**Claims process when you have the Original Medicare Plan** – You 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 claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800-884-4901 or see our Web site at [www.firstcare.com](http://www.firstcare.com).

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at [www.medicare.gov](http://www.medicare.gov).

If you enroll in a Medicare Advantage plan, the following options are available to you:

**This Plan and another plan's Medicare Advantage plan:** You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

**Suspended FEHB coverage to enroll in a Medicare Advantage plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

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

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

## **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 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, 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.

## **Medicaid**

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

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

## **When other Government agencies are responsible for your care**

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

## **When others are responsible for injuries**

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.

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## Section 10 Definitions of terms we use in this brochure

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<b>Calendar year</b>	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.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 11.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 11.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	<p>Custodial care is care that:</p> <ul style="list-style-type: none"><li>• Primarily helps with or supports daily living activities (such as, eating, dressing, and eliminating body wastes); or</li><li>• Can be given by people other than trained medical personnel.</li></ul> <p>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.</p> <p>Custodial care that lasts 90 days or more is sometimes known as Long term care.</p>
<b>Experimental or investigational services</b>	<p>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:</p> <ul style="list-style-type: none"><li>• 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;</li><li>• 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;</li><li>• 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</li><li>• The prescribed service or supply is available to the member only through participation in FDA Phase I or Phase II clinical trials, or through FDA Phase III experimental or research clinical trials or corresponding trials sponsored by the National Cancer Institute.</li></ul>
<b>Group health coverage</b>	Health coverage, such as FEHB, that is provided through an employer group.
<b>Medical necessity</b>	<p>Medical necessity and/or medically necessary means that the service must meet <i>all</i> of the following conditions:</p> <ul style="list-style-type: none"><li>• The service is required for diagnosing, treating or preventing an illness or injury, or a medical condition such as pregnancy;</li><li>• 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;</li><li>• It is generally accepted as safe and effective under standard medical practice in your</li></ul>

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 FIRSTARE

**You**

You refers to the enrollee and each covered family member.

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## Section 11 FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

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

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

See [www.opm.gov/insure/health](http://www.opm.gov/insure/health) for enrollment as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, 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 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.

- **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 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 cancel your coverage, change to Self Only, or change to a plan that doesn’t serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2005 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **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 (TCC), or a conversion policy (a non-FEHB individual policy.)

- **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 provide 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 Web site, [www.opm.gov/insure](http://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 Federal 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](http://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 at [www.opm.gov/insure/health](http://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 information about Federal and State agencies you can contact for more information.

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## Section 12 Two Federal Programs complement FEHB benefits

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### Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

### The Federal Flexible Spending Account Program – *FSAFEDS*

#### • What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

#### Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

#### Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return and who is mentally or physically incapable of self care.
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year.

#### • Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled for 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

- Online: visit [www.fsafeds.com](http://www.fsafeds.com) and click on Enroll.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

#### What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

## Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAFEDS accounts. *However, if you enroll in an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

*Note:* FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

## • How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “Use-it-or-Lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005 until March 15, 2006 to incur eligible expenses and, you may submit claims for those expenses through May 31, 2006.

The FSAFEDS Calculator at [www.FSAFEDS.com](http://www.FSAFEDS.com) will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

## • What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page xx and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the High Option of this plan, typical out-of-pocket expenses include:

Under the Standard Option of this plan, typical out-of-pocket expenses include:

Under the Consumer Driven Health Plan, typical out-of-pocket expenses include:

Under the High Deductible Health Plan, typical out-of-pocket expenses include:

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at [www.FSAFEDS.com/fsafeds/eligibleexpenses.asp](http://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp). If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

<b>Annual Tax Savings Example</b>	<b>With FSA</b>	<b>Without FSA</b>
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
<b>Your tax savings:</b>	<b>\$576</b>	<b>-\$0-</b>

**Note:** This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

- **Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

**Paperless Reimbursement** – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. You must re-enroll every Open Season to remain in the paperless reimbursement program. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

- **Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit [www.FSAFEDS.com](http://www.FSAFEDS.com) and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance during your period of coverage for the Plan Year plus 2 ½ month grace period, resulting in the forfeiture of funds remaining in your account (the IRS "Use-it-or-Lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at [www.FSAFEDS.com](http://www.FSAFEDS.com), or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time.

- E-mail: [FSAFEDS@shps.net](mailto:FSAFEDS@shps.net)
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

## **The Federal Long Term Care Insurance Program**

- **It's important protection**

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

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

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## Summary of benefits for FIRSTCARE - 2006

- **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
<b>Medical services provided by physicians:</b>		
Diagnostic and treatment services provided in the office	Office visit copay: \$20 primary care; \$40 specialist	14
<b>Services provided by a hospital:</b>		
<ul style="list-style-type: none"> <li>• Inpatient</li> </ul>	\$100 per day up to a maximum of \$500 per admission at a contracted facility within our 108 county service area; or \$200 per day up to a maximum of \$1,000 per admission at a contracted facility outside of our 108 county service area	29
<ul style="list-style-type: none"> <li>• Outpatient</li> </ul>	\$200 per visit	30
<b>Emergency benefits:</b>		
<ul style="list-style-type: none"> <li>• In-area</li> </ul>	\$100 per visit	32
<ul style="list-style-type: none"> <li>• Out-of-area</li> </ul>	\$100 per visit	33
<b>Mental health and substance abuse treatment:</b>	Regular cost sharing	34

*Summary - continued on next page*

Benefits	You pay	Page
<b>Prescription drugs:</b>		36
<ul style="list-style-type: none"> <li data-bbox="94 310 862 338">Retail pharmacy (up to a 30-day supply per prescription unit or refill)</li> </ul>	A \$10 copay for Tier 1 generic drugs; A \$20 copay for Tier 2 Limited listed Name Brand drugs when a generic equivalent is not available; A \$40 copay for Tier 3 Other Name Brand drugs; and A 25% coinsurance for Self-injectable drugs (except for insulin and glucagons) and other High Technology Drugs.	37
<ul style="list-style-type: none"> <li data-bbox="94 663 800 690">Mail order (up to a 90-day supply per prescription unit or refill)</li> </ul>	A \$30 copay for Tier 1 generic drugs; A \$60 copay for Tier 2 Name Brand drugs when a generic equivalent is not available; A \$120 copay for Tier 3 Name Brand drugs; and A 25% coinsurance for Self-injectable drugs (except insulin and glucagons) and other High Technology Drugs.	37
<b>Dental care:</b>	No benefit.	41
<b>Vision care:</b>	Nothing during office visit.	14
<b>Special features: Services for deaf and hearing impaired; Centers of excellence for transplants/heart surgery/ etc.</b>		40
<b>Protection against catastrophic costs (out-of-pocket maximum):</b>	Nothing after 200% of annual premium/Self Only or 200% of annual premium/Family enrollment. Some costs do not count toward this protection	11

## 2006 Rate Information for FIRSTCARE

**Non-Postal rates** apply to most non-Postal employees. 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 a special FEHB guide is published 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.

Type of Enrollment	Enrollment Code	<i>Non-Postal Premium Biweekly Government Share</i>	<i>Non-Postal Premium Biweekly Your Share</i>	<i>Non-Postal Premium Monthly Government Share</i>	<i>Non-Postal Premium Monthly Your Share</i>	<i>Postal Premium Biweekly USPS Share</i>	<i>Postal Premium Biweekly Your Share</i>
Central Texas Self Only	6U1	\$121.22	\$40.41	\$262.65	\$87.55	\$143.45	\$18.18
Central Texas Self and Family	6U2	\$260.63	\$86.87	\$564.69	\$188.23	\$308.41	\$39.09
West Texas Self Only	CK1	\$139.18	\$58.18	\$301.56	\$126.05	\$164.31	\$33.05
West Texas Self and Family	CK2	\$316.08	\$108.25	\$684.84	\$234.54	\$373.15	\$51.18